IN RE: THE INVESTIGATION OF FAILURES TO REPORT ALLEGATIONS OF UNPROFESSIONAL CONDUCT AND CHILD ABUSE AGAINST DR. EARL BRADLEY UNDER DELAWARE LAW PRIOR TO 2008

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I. INTRODUCTION

On January 7, 2010, the Attorney General directed the State Solicitor to evaluate whether any individuals or entities failed to comply with any affirmative legal obligation under Delaware law to report suspected unprofessional conduct or child abuse committed by then-Delaware-licensed pediatrician Dr. Earl Bradley prior to December 2008. This report is limited to pre-December 2008 events because, in 2008, allegations against Dr. Bradley prompted law enforcement to open a new investigation into Dr. Bradley's conduct. That investigation has resulted in Dr. Bradley's arrest and is now proceeding to trial. As explained below in more detail, to ensure that we do not jeopardize the ongoing criminal prosecution of Dr. Bradley, an investigatory privilege attaches that precludes the investigation and prosecution from our review. In addition, pursuant to an order of the Superior Court and Rule 3.6 of the Delaware Lawyers' Rules of Professional Conduct, we are constrained from extra-judicial comment concerning Dr. Bradley's criminal prosecution that might prejudice the fair trial rights of the accused. Specifically, this report investigates:

> (1) Which individuals and/or entities had a duty to report to the Delaware Board of Medical Practice ("BMP" or "Board"), or the Delaware Division of Professional Regulation ("DPR" or "Division") prior to December 2008;
> (2) Which individuals and/or entities had a duty to report to the Department of Services for Children, Youth and Their Families, Division of Family Services ("DSCYF" or "DFS") prior to December 2008, and;
> (3) Whether any mandatory reporters complied with their statutory reporting duties prior to December 2008.

As part of this investigation, the State Solicitor issued subpoenas to medical doctors, hospitals, medical associations, and law enforcement agencies. To the extent that the subpoenas were resisted in whole or in part, immediate legal action was pursued to compel production of all documentary and testimonial evidence requested to complete the record. Numerous witnesses

from law enforcement agencies and the medical community were interviewed. Finally, we sought the input of nationally-recognized experts on mandatory reporting laws for medical providers and law enforcement agencies.

This report summarizes the information accumulated during our investigation, explains the conclusions we reached, and details the recommendations we propose based on our application of the law to the relevant facts. With that background, this report is organized into three sections to provide (1) an overview of the applicable law, (2) a summary of the evidence reviewed and findings regarding mandatory reporter compliance, and (3) legislative and policy recommendations informed by those findings.

II. APPLICABLE LAW

A. MEDICAL PRACTICE ACT MANDATORY REPORTING LAW

The Board of Medical Practice is charged with protecting Delaware health care system patients through the proper licensing and regulation of physicians and other health care professionals. The Division of Professional Regulation facilitates the BMP with its statutory charge by investigating complaints against these licensees. Upon the completion of DPR investigations into medical licensee conduct, the BMP conducts hearings, adjudicates the complaints, and imposes disciplinary sanctions against medical licensees for violations of the *Medical Practice Act*, 24 *Del. C.* ch. 17 ("MPA"), or the Board's rules and regulations.

Section 1731A of the MPA requires certain statutorily-enumerated entities and individuals to report to the Board a "*reasonable belief*" that a licensed medical doctor has engaged in "*unprofessional conduct*" "*in writing within 30 days of becoming aware of the information*."[1] Mandatory reporting of unprofessional physician conduct serves to alert the BMP of the need to investigate and determine whether to initiate disciplinary action against a physician about whom it has received a complaint. It is noteworthy that the section 1731A mandatory reporting requirements are not limited to doctors licensed and regulated by the Board, but also extend to hospitals and state agencies that the Board lacks any jurisdiction to license or discipline.

Specifically, the MPA imposes an affirmative duty to report "*unprofessional conduct*" committed by a licensed physician on:

> (1) All persons certified to practice medicine under [the MPA];
> (2) All certified, registered, or licensed healthcare providers;

[1] The duty to report unprofessional physician conduct first appeared in an amendment to the MPA on February 2, 1990. 67 *Del. Laws*, c. 159, § 1.

(3) The Medical Society of Delaware;
(4) All health care institutions in this State;
(5) All State agencies; and
(6) All law enforcement agencies in the State.[2]

The MPA does not provide a precise definition of "*unprofessional conduct*." Instead, it defines "*unprofessional conduct*" to include (but not be limited to) twenty-one (21) specified categories of prohibited licensee conduct, most of which are specific to the practice of medicine.[3] A reasonable belief that a medical licensee has engaged in any of these 21 specified categories of conduct triggers a mandatory duty to report that individual, in writing, to the Division of Professional Regulation. Such conduct includes, *but is not limited to*:

- A conviction of or admission under oath to having committed a crime substantially related to the practice of medicine. 24 *Del. C*. § 1731(b)(2).
- Any dishonorable, unethical, or other conduct likely to deceive, defraud, or harm the public. 24 *Del. C*. § 1731(b)(3).
- The use, distribution, or issuance of a prescription for a dangerous or narcotic drug, other than for therapeutic or diagnostic purposes. 24 *Del. C*. § 1731(b)(6).
- Misconduct, incompetence, or gross negligence in the practice of medicine. 24 *Del. C*. § 1731(b)(11).

Insofar as penalties for duty to report violations are concerned, the MPA provides that "[a] person who violates [the duty to report] is subject to a fine of not less than $250 nor more than $5,000."[4]

The most troublesome and overarching issue presented by the MPA, as currently written, is whether the Board has any jurisdiction to enforce the section 1731A reporting requirements by imposition of a fine or otherwise upon the enumerated mandatory reporters who do not hold

[2] 24 *Del. C*. § 1731A(a).
[3] 24 *Del. C*. § 1731(b)(1-21).
[4] 24 *Del. C*. § 1731A(i). The Joint Sunset Committee ("JSC") of the General Assembly conducted a comprehensive review of the BMP and the Medical Practice Act in 2002. At the conclusion of its review, the JSC recommended, *inter alia*, an increase in the section 1731A(i) failure to report penalty, which at that time was no less than $50 nor more than $250. Section 1731A(i) was amended in 2005 to provide for $250 to $5,000 range of fines. *See* 75 *Del. Laws* c. 141 § 1.

medical licenses (*i.e.*, state agencies, hospitals, law enforcement agencies, *etc*.). The MPA uses the term "fine" as a disciplinary sanction against a doctor. *See* 24 *Del. C.* § 1731(a) (stating that "[a] person to whom a certificate to practice medicine in this State has been issued may be disciplined by the Board for unprofessional conduct . . . by means of levying a fine"). Such fines are civil administrative penalties that the BMP can impose, but only on a medical licensee and only after the Board conducts an administrative disciplinary hearing that comports with the MPA.

Section 1731A of the MPA also uses the term "fine" as a sanction for failure to report unprofessional physician conduct up to the same $5,000 limit that the Board can levy as administrative discipline. There is no explicit language in section 1731A, however, that specifies which entity or tribunal has the authority to enforce the section. Arguably, section 1713(a) of the MPA, which enumerates the Board's powers and extends them to "other powers and duties set forth elsewhere in this chapter" vests the Board with jurisdiction to enforce the section 1731A mandatory reporting requirements. Such an interpretation is problematic, however, because section 1731A, on its face, does not provide the Board with any enforcement authority over non-licensee mandatory reporters.

Section 1701 of the MPA articulates the "purpose" of the Board of Medical Practice as follows:

> Recognizing that the practice of medicine and the practices of certain other healthcare professions are privileges and not natural rights, it is hereby considered a matter of policy in the interests of public health, safety, and welfare to provide laws covering the granting of those privileges and their subsequent use and control, and to provide regulations to the end that the public health, safety, and welfare are promoted and that the public is properly protected from the unprofessional, improper, unauthorized, or unqualified practice of medicine . . . .[5]

[5] 24 *Del. C*. § 1701.

To effectuate this purpose, that is, the regulation of medical practitioners and the practice of medicine, the statutory powers vested in the Board of Medical Practice are primarily two-fold: (1) the issuance of certificates to practice medicine and (2) the discipline of medical professionals. In other words, the Board is empowered to determine whether or not an applicant for a medical license meets the necessary qualifications to practice medicine as well as investigate and take disciplinary action against licensed physicians responsible for gross negligence, unethical behavior, unprofessional conduct or incompetence.

As the Board's purpose makes clear, the primary goal of and justification for licensing and regulating medical professionals is public protection. As an extension of the state's police power, the medical board's licensure and disciplinary authority is aimed at protecting patients from the harms they may incur at the hands of incompetent or unethical physicians. This is reflected in: (1) the composition of the Board, which is predominantly composed of medical doctors; (2) the Board's broad discretion to exclude individuals from the practice of medicine via its power to grant or deny a license; and (3) the sanctions that the Board is entitled to impose on physicians and only physicians, which range from alerting the medical board and community of a potential for harm (via a public letter of reprimand) to permanently withdrawing the physician's right to practice (revocation). In other words, the goals of medical licensure and licensee discipline are incapacitation and public protection.[6] Therefore, public policy and common sense dictate that, while the BMP has expansive power to regulate the practice of medicine and medical professionals, it has no power to regulate individuals or entities not engaged in the practice of medicine.

[6] Professional discipline does not serve to compensate victims, like civil law or punish wrongdoers, like criminal law.

Consistent with this general proposition, there is only one class of persons that are neither medical licensees nor medical licensure applicants[7] over whom it is clear the Board has jurisdiction: individuals engaged in the unauthorized practice of medicine. Unsurprisingly, all Title 24 professional licensing boards, including the Board of Medical Practice, have jurisdiction over persons engaged in the unauthorized practice of the professions they regulate under the Delaware *Administrative Procedures Act*, ("APA"), 29 *Del. C*. ch. 101. Section 10161(c) of the APA provides as follows:

> [a]ny professional licensing board governed by Title 24 . . . upon notice, hearing and review . . . may issue a cease and desist order to a person that the Board determines is engaged in the practice of the profession regulated by the Board without having lawfully obtained a license or that a person previously licensed by the Board is engaged in the regulated practice of the profession notwithstanding that the person's license has lapsed, expired or has been suspended or revoked.

Subject to notice, hearing and review, APA section 10161(d) also permits the licensing boards to "fine any person who violates a cease and desist order not less than $100 or more than $1000." Moreover, and most importantly, the APA creates, as it must, a mechanism for the licensing boards to enforce actions they take against non-licensees: specifically, resort to the courts. APA section 10161(d) explicitly empowers the boards to "seek injunctive relief to prevent unauthorized practice of the profession."

Unlike APA section 10161, MPA section 1731A is silent with regard to any process or procedures the Board must follow prior to its imposition of a fine on mandatory reporters who violate the section. Worse, section 1731A fails to provide the Board with any mechanism whatsoever to enforce the imposition of a fine on a mandatory reporter who runs afoul of its

[7] It is worth noting that licensure applicants voluntarily subject themselves to the Board's jurisdiction and only for a limited purpose: to make a determination on their licensure applications.

reporting requirements. In addition, the language of APA section 10161 explicitly empowers the boards to impose cease and desist orders and fines (*i.e.*, the licensing boards "may issue a cease and desist order" and "may fine"). MPA section 1731A(i), by contrast, states that "a person who violates a provision of this section is subject to a fine of not less than $250 nor more than $5,000," but gives no indication who or what tribunal may impose a fine. Finally, whereas APA section 10161 empowers each Title 24 board with limited jurisdiction over non-licensees *only* to prevent the unauthorized practice of the profession it regulates, MPA section 1731A purports to empower the Board of Medical Practice with jurisdiction over non-licensees not engaged in the unauthorized practice of any profession let alone the practice of medicine, apparently permitting the BMP to reach where no other Title 24 board can. Thus, while one could interpret section 1713(a)[8] of the MPA to mean that the BMP may exercise jurisdiction to discipline non-licensee mandatory reporters who fail to comply with the MPA's reporting requirements, such interpretation neither comports with the purposes of professional licensure or discipline nor cures the aforementioned due process and enforcement defects.

Unfortunately, section 1731A's jurisdictional issues do not end there. Section 1731A(i) of the MPA permits a fine to be levied only against "[a] *person* who violates" the mandatory reporting requirements of section 1731A. The MPA, however, does not define the word "person." Review of other sections of the Delaware Code[9] teaches that the word "*person*," when used in a statute, includes individuals and various organized business entities. So, while a hospital may be considered a "*person*" subject to the mandatory reporting requirement, state and

[8] 24 *Del. C*. § 1713(a) states "[t]he Board has the following powers and duties, *in addition to other powers and duties set forth elsewhere in this chapter* . . . ."

[9] 1 *Del. C*. § 302(16) (providing that person "include[s] corporations, companies, associations, firms, partnerships, societies and joint-stock companies, as well as individuals").

law enforcement agencies may not. As a result, even though the MPA imposes a mandatory reporting obligation on state and law enforcement agencies, the Act imposes penalties for failure to comply with that reporting obligation only on *persons* and not on agencies. Indeed, the DPR noted this statutory discrepancy in its response to the BMP's 2007 Joint Sunset Committee ("JSC") performance evaluation:

> Some provisions of Delaware Code 24 § 1731A are unenforceable. Although physicians can be fined for violating the law, the board cannot impose fines on non-licensees, such as hospitals. In checking with the Office of Healthcare Facilities and Licensing, its statute does not provide any penalty to enforce this mandate. To ensure that license infractions are properly reported, consideration should be given to instituting significant penalties for non-compliance of healthcare facilities.

In other words, the DPR acknowledged that the BMP lacks jurisdiction to impose fines on section 1731A mandatory reporting *entities* and *non-licensees* as opposed to *licensed individuals*.

The MPA also raises the thorny question of whether a law enforcement agency's duty to report is triggered when a criminal investigation of a licensed medical doctor *does not* result in the arrest or conviction of that doctor. Among other public safety functions, law enforcement agencies investigate potential criminal misconduct. Obviously, matters of medical malpractice or violations of medical standards are beyond the ken of law enforcement personnel, particularly without substantial assistance from medical experts. Section 1731(b)(2) imposes on law enforcement agencies a duty to report "*criminal* unprofessional conduct" committed by a licensed medical doctor to the BMP within 30 days of that doctor's *conviction* of, or *admission* under oath to, a crime substantially related to the practice of medicine.

It is clear that a law enforcement agency's duty to report unprofessional conduct to the BMP would not be triggered under this subsection until a medical licensee either has been convicted of, or pled guilty to, a crime. Nonetheless, if the MPA is interpreted literally, law

enforcement agencies' duty to report goes well-beyond the criminal conduct provision in section 1731(b)(2). On its face, section 1731A imposes on law enforcement a duty to report the full panoply of "unprofessional conduct" outlined in section 1731(b).

The section 1731A reporting requirements pose serious practical concerns for law enforcement agencies. By statute, a complaint of physician unprofessional conduct filed with the DPR "shall state the name of the licensee and sufficient facts as determined by the Division which allegedly constitute the basis for the written complaint."[10] "[The] Division of Professional Regulation shall thereafter mail a copy of the complaint to the licensee named . . . ."[11] Moreover, section 1733(d) the MPA provides as follows:

> After investigation, if the Executive Director elects to file a formal written complaint against a person to whom a certificate to practice medicine has been issued, the person *must be served* personally or by certified mail, return receipt requested, with a copy of the complaint . . . . A formal written complaint under this subsection must *describe in detail the allegations upon which the complaint is based*.[12]

Therefore, should a law enforcement agency file a section 1731A report with the DPR or Board concerning a doctor under investigation, both the DPR and Board are mandated by statute to then provide that doctor with a copy of that complaint, which must *describe in detail* the allegations against the doctor, as well as notice to that doctor that a law enforcement agency is the complainant. In other words, by law, a doctor under criminal investigation who is reported to the DPR or Board will be informed of the pending administrative complaint and, as a result, could destroy evidence, intimidate witnesses or flee before the law enforcement agency could

[10] 29 *Del. C*. § 8735(h)(2).
[11] *Id*. at § 8735(h)(4).
[12] 24 *Del. C*. § 1733(d).

complete its criminal investigation or take the necessary steps to make an arrest or effectuate a search warrant.

In order to minimize the ability of criminal suspects to engage in such justice-obstructing behavior, the Delaware Courts have consistently stated that the Attorney General and law enforcement agencies hold a common law "*governmental investigatory privilege*" to prevent from disclosure information obtained in furtherance of a criminal prosecution.[13] The purposes of the investigatory privilege are numerous and include as follows: (1) to prevent interference with an investigation or law enforcement proceeding, *e.g.*, revelation of the direction or other confidential details of the investigation, premature revelation of the government's case thereby facilitating the construction of defenses, closing channels of useful, voluntarily submitted information, identification of prospective new defendants, revelation of subjects of the investigation, and methods of surveillance; (2) to prevent disclosure of confidential investigative techniques, procedures, and activities; (3) to prevent injury to government effectiveness, *e.g.*, witness intimidation, threats to government agents or officials, spoliation of criminal evidence, and impaired agency functioning; (4) to prevent the restriction of governmental access to confidential sources of information; and (5) the public interest in ensuring candid conclusions and recommendations by governmental agencies.[14]

The investigatory privilege also enables the Attorney General to fulfill his constitutional power to prosecute crime in the manner he discerns best *protects public safety and the public interest*. As the Court of Chancery recently explained:

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[13] *See, e.g.*, *Beckett v. Trice*, C.A. No. 92C-08-029, 1994 WL 319171 (Del. Super. June 6, 1994) (citing *State v. Brown*, 36 A. 458, 463-64 (Del. Oyer. and Term. 1896)).
[14] *See generally* Murl A. Larkin, Federal Testimonial Privileges § 5.02[3] (1993).

> . . . the State is not required to disclose facts coming to [its] knowledge for the use of the state in its prosecution of the accused. Communications between a witness and a prosecutor are regarded as secrets of state, or matters the disclosure of which would be *prejudicial to the public interests*. Such communications are protected, and all evidence thereof [will be] excluded.[15]

The investigatory privilege also is recognized by and codified in the Delaware Superior Court Criminal Rules, which specifically state that they do not "authorize the discovery or inspection of reports, memoranda, or other internal state documents made by the attorney general . . . in connection with the investigation or prosecution of the case."[16] Consistent with the common law investigatory privilege and Superior Court Criminal Rules, the State's *Freedom of Information Act* ("FOIA") is explicit that investigatory files are not public records and, as a result, not subject to disclosure.[17] We understand that FOIA exemptions and privileges sometimes are not coextensive but, in enacting FOIA, the General Assembly expressly recognized the desirability of maintaining the confidentiality of investigatory files and, thus, included them within the exemption provisions of the act.

Delaware's recognition of an investigative privilege is by no means unique. The federal courts have held repeatedly that the investigative privilege presumptively protects the information contained in files related to law enforcement investigations—whether through documents or deposition testimony—that would harm a federal agency's enforcement or investigative efforts.[18] Attorney General (and later, Supreme Court Justice) Robert Jackson expressed similar sentiments in April 1941:

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[15] *State ex rel. Brady v. Ocean Farm Ltd. Partnership*, C.A. No. A. 2036-S, 2002 WL 259955, at *2 (Del. Ch. Feb, 14, 2002) (emphasis added).
[16] Del. Super. Ct. Crim. R. 16(a)(2).
[17] 29 *Del. C*. § 10002(d)(3).
[18] *See, e.g.*, *In re Sealed Case*, 856 F.2d 268, 272, 317 (D.C. Cir. 1988) (public interest in safeguarding integrity of civil and criminal investigations supports application of investigative

> Disclosure of the [investigatory] reports could not do otherwise than *seriously prejudice law enforcement*. Counsel for a defendant or prospective defendant, could have no greater help than to know how much or how little information the Government has, and what witnesses or sources of information it can rely upon.[19]

To the extent that section 1731A demands that law enforcement agencies report medical licensees to the DPR or Board prior to the conclusion of a criminal investigation into those licensees, section 1731A is in conflict with the law enforcement investigatory privilege as well as its purposes and, as a result, is prejudicial to the public interest.

Another difficulty facing law enforcement agencies under section 1731A is this: which agency must make a report to the Board when more than one law enforcement agency is conducting a criminal investigation? The normal course of police practice suggests that one agency would take the responsibility of reporting. However, section 1731A(a) imposes the affirmative duty to report on "[a]ll law enforcement agencies in the State." Therefore, we must assume for purposes of this report that each law enforcement agency involved in an investigation has an independent duty to report.

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privilege to both investigatory files and deposition testimony that would disclose the contents or information in those files); *see also Dellwood Farms v. Cargill, Inc.*, 128 F.3d 1122, 1125 (7th Cir. 1997) (recognizing the "law enforcement investigatory privilege"); *United States v. Winner*, 641 F.2d 825, 831 (10th Cir. 1981) (stating that the "law enforcement investigative privilege is based primarily on the harm to law enforcement efforts which might arise from public disclosure of investigatory files"); *In re Dep't of Investigation*, 856 F.2d 481, 483-84 (2d Cir. 1988); *Tuite v. Henry*, 181 F.R.D. 175, 176-77 (D.D.C. July 31, 1998), *aff'd*, 203 F.3d 53 (D.C. Cir. 1999) ("The federal law enforcement privilege is a qualified privilege designed to prevent disclosure of information that would be contrary to the public interest in the effective functioning of law enforcement. [It] serves to preserve the integrity of law enforcement techniques and confidential sources, protects witnesses and law enforcement personnel, safeguards the privacy of individuals under investigation, and prevents interference with investigations.").

[19] 40 *Op. Att'y Gen.* 45, 46 (1941); *see also* 10 *Op. Att'y Gen.* 68, 76 (1986) (citing the "well-founded fears that the perception of the integrity, impartiality, and fairness of the law enforcement process as a whole will be damaged if sensitive material is distributed beyond those persons necessarily involved in the investigation and prosecution process").

As explained above, the section 1731A duty to report is triggered by a "*reasonable belief*" that a doctor is or may be guilty of unprofessional conduct. The MPA, however, does not define "*reasonable belief*" and there are no reported Delaware cases construing that term. Case law from other states deducing "*reasonable belief*" in the context of mandatory child abuse reporting requirements make clear that, when construing the meaning of "*reasonable belief*," courts apply an objective standard and look to the totality of the circumstances, *i.e*., determine whether a reasonable person in similar circumstances would believe that child abuse has occurred or is occurring.[20] That is, rumor, hunch or innuendo is not enough to trigger a mandatory duty to report.[21] Instead, the objective standard applied to the reporting requirement encompasses the totality of facts and circumstances actually known to the individual who has the mandatory duty to report.[22]

A person's reasonable belief that child abuse is being committed often depends on that individual's professional training and experience. In many cases, individuals become aware of a possible case of child abuse only through second-hand reports or ambiguous physical symptoms and it is unclear whether such circumstances constitute reason to believe that such conduct may be taking place.[23] "A statute that conditions the requirement to report on these difficult judgment calls does not clearly define what conduct is required in many conceivable situations."[24] "Determining whether abuse is, or may be occurring in a particular case is likely to be especially difficult for untrained laypersons."[25] As a result, "[m]ost states place such a requirement only on

[20] *State v. Hurd*, 400 N.W.2d 42 (Wis. App. 1986).
[21] *Id*.
[22] *Id*.
[23] *Perry v. S. N.,* 973 S. W. 2d 301, 307 (Tex. 1998).
[24] *Id*.
[25] *Id.* at 307 n.6.

professionals to know more than the average person about recognizing child abuse and who have a professional relationship and responsibility for children."[26] While this reasoning supports the proposition that state and law enforcement agencies are mandated to report only criminal convictions or pleas under section 1731(b)(2) of the MPA, we will assume for purposes of this report that the Delaware General Assembly intended to impose on all "mandatory reporters"– including law enforcement—the responsibility to report any reasonable belief of unprofessional physician conduct.

B. CHILD ABUSE PREVENTION ACT MANDATORY REPORTING LAW

In addition to the mandatory reporting requirements of the *Medical Practice Act*, the *Child Abuse Prevention Act*, 16 *Del. C.* ch. 9, imposes on "*any person*" a mandatory duty to report incidents of *suspected child abuse or neglect* to the Division of Family Services. The pertinent provisions of that Act provide as follows:

> **16 *Del. C.* § 903**
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> Any physician, and any other person in the healing arts including any person licensed to render services in medicine, osteopathy, dentistry, any intern, resident, nurse, school employee, social worker, psychologist, medical examiner or any other person who knows or in good faith suspects child abuse or neglect shall make a report in accordance with §904 of this title. In addition to and not in lieu of reporting to the Division of Family Services, any such person may also give oral or written notification of said knowledge or suspicion to any police officer who is in the presence of such person for the purpose of rendering assistance to the child in question or investigating the cause of the child's injuries or condition.
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> **16 *Del. C.* § 914(a)**
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> Whoever violates §903 of this title shall be liable for a civil penalty not to exceed $5,000 for the first violation and not to exceed $50,000 for any subsequent violation.

[26] *Id*.

"[A]ll fifty states have codified mandatory reporting statutes that impose a duty to report suspected or observed child abuse upon specified persons or institutions, particularly those that work regularly with children."[27] Delaware's codification of child abuse reporting statutes dates back to 1976.[28] In 1997, the General Assembly amended and re-codified those statutes in the *Child Abuse Prevention Act*,[29] which "imposes a duty to report suspected child abuse or neglect upon employees in certain professions who work closely with children, such as physicians, teachers, and social workers. Those people have a statutory duty to report reasonably suspected child abuse or neglect."[30]

The mandatory duty to report suspected child abuse is not limited to acts committed by "parents, guardians, or other legally responsible persons."[31] "[W]henever anyone knows or reasonably suspects child abuse or neglect, a report must be made. The requirement for a report is not limited by who commits the acts of abuse or neglect."[32] The list of persons required to report suspected child abuse includes physicians, nurses, psychologists, school employees, social workers and "any other person who knows or in good faith suspects child abuse or neglect."[33]

While it could be argued that the specific enumeration of professional classes of individuals imbued with the reporting requirement somehow limits the class of mandatory reporters, we do not see any such limitation in the plain language of the statute. In any event, we

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[27] *Rhone v. Dickerson*, C.A. No. 03-06-0143, 2003 WL 22931336, at *2 (Del. Com. Pl. Oct. 16, 2003) (quoting *Dobson v. Harris*, 530 S.E.2d 829, 833 (N.C. 2000)).
[28] *See* 60 *Del. Laws*, c. 464 (1976) (*Child Abuse Prevention and Treatment Act*).
[29] 16 *Del. C.* § 903.
[30] *Drake v. State*, 682 A.2d 626, 627, 1996 WL 343822, at *2 (Del. June 13, 1996).
[31] *Del. Att'y Gen. Op.* 77-2, 1977 WL 25936, at *2 (Jan. 10, 1977).
[32] *Id.*; *see* 16 *Del. C.* § 902(1) (defining "abuse" as "any physical injury to a child by those responsible for the *care*, custody, and control of a child") (emphasis added)).
[33] 16 *Del. C.* § 903.

recognize that, particularly in the case of child sexual abuse, individuals with specialized training may have unique sensitivities that provide them a heightened sense of a "good faith suspicion."

Unlike section 1731A, section 903 mandatory reporters include only individuals and not agencies or institutions. Indeed, section 903 differs from section 1731A in a number of important respects: the classes of cases that must be reported differ significantly, the classes of individuals subject to the reporting requirements differ, and the entity to which the mandatory report must be made differ.

Like the current laws in 45 other states, the *Child Abuse Prevention Act* originally mandated criminal penalties for failure to comply with its mandatory reporting provisions.[34] In 2009, however, the General Assembly amended the act to change the penalty for a section 903 violation from a criminal to a civil fine. The law now states: "Whoever violates §903 of this title shall be liable for a civil penalty not to exceed $5,000 for the first violation and not to exceed $50,000 for any subsequent violation."[35] Unfortunately, the enforcement history of the *Child Abuse Prevention Act*'s mandatory reporting provision is no better than that of the *Medical Practice Act*. We have not found a single reported Delaware case where any court either convicted or imposed a civil penalty on any person for failure to report suspected child abuse under section 903. With this general overview of the pertinent law, we now turn to a summary of the evidence we have acquired in conducting this compliance review.

[34] 71 *Del. Laws* 1997, c. 199 § 6 (stating "[w]hoever knowingly violates §903 of this title shall be fined not more than $1,000 or shall be imprisoned not more than 15 days or both").
[35] 16 *Del. C.* § 914(a).

III. SUMMARY OF THE EVIDENCE

We have identified several persons and entities that potentially had a legal obligation to file complaints against Dr. Bradley in 2004-05 under either section 1731A for unprofessional conduct or section 903 for child abuse. These mandatory reporters consist of health care institutions and associations, doctors, and law enforcement agencies. Each is discussed in turn by category below. The standard of review we applied to reach findings with regard to these mandatory reporters is whether, in light of the information known to them at the relevant time, there is a reasonable basis to conclude they failed to comply with their affirmative duty to report Dr. Bradley for suspected misconduct in violation of Delaware law. These findings do not represent a conclusive determination of wrongdoing because the mandatory reporters discussed below have not been afforded adequate notice, the benefit of discovery, the ability to present witnesses and formal defenses, or adjudication by a proper trier of fact.

A. BACKGROUND

On December 8, 1993, Dr. Bradley applied to the Delaware Board of Medical Practice ("BMP") for a Delaware medical license. At that time, he was practicing medicine in Philadelphia, Pennsylvania. On April 12, 1994, subsequent to the Board's licensure review process, the Delaware BMP granted Dr. Bradley his Delaware medical license. Records obtained from the Pennsylvania Bureau of Professional Occupational Affairs ("PBPOA") indicate that, on June 28, 1994, the PBPOA Complaints Office received a letter from a woman who alleged that Dr. Bradley had sexually molested her twenty-one-month-old daughter during an office visit in Philadelphia on June 17, 1994. Just weeks later, Dr. Bradley moved to Lewes, Delaware.

The Pennsylvania complainant reported the incident to the Philadelphia Police Department on the day it occurred. The complainant told police that she had observed Dr. Bradley with his hand down the front of her daughter's diaper. The police conducted an investigation into the complaint. The investigating police officer noted that the complaining witness took her daughter to a local hospital after the office visit with Dr. Bradley where her daughter was to be examined for signs of sexual abuse. The complaining witness and her daughter ultimately left the hospital after a long wait and before hospital staff conducted any examination.

On July 1, 1994, the Delaware Board of Medical Practice's Executive Director sent a letter to the PBPOA explaining that it was in receipt of the June 24, 1994 Pennsylvania complaint against Dr. Bradley and stating that "[b]ecause of the major problems that would be involved if we were to try to conduct an investigation in your jurisdiction" it was requesting copies of any other complaints or investigations against Dr. Bradley. *See* Exhibit 1. On April 7, 1995, the PBPOA notified the Delaware BMP that the Pennsylvania administrative prosecutor had decided not to prosecute Dr. Bradley. *See* Exhibit 2.[36]

On May 8, 1995, the Delaware BMP's Executive Director informed the PBPOA via letter that, in light of the PBPOA's decision not to prosecute, the Delaware BMP closed out the complaint with "[n]o further action . . . contemplated." *See* Exhibit 3. The Executive Director's May 8 letter goes on to state "[a]s you well know, since the alleged infraction occurred in Pennsylvania, we were unable to do our own investigation. We relied on you, and you came through for us." Under section 1731A in the 1994 version of the MPA, the Delaware BMP *was*

[36] The Pennsylvania file also included the complaint and a memo detailing the reasons for closing the investigation against Dr. Bradley. *See* Exhibit 2.

required to conduct an investigation into the Philadelphia complaint it received against Dr. Bradley rather than defer to any investigation conducted by its Pennsylvania counterpart.[37] The Executive Director's May 8, 1995 letter also asserts that the BMP's "current practice is that the investigative file will be incorporated into Dr. Bradley's permanent licensure file." Nevertheless, none of the correspondence between the BMP and the PBPOA with regard to the June 24, 1994 complaint against Dr. Bradley was provided to the DOJ in the BMP's response to our request for documents pursuant to 29 *Del. C*. § 2504(4).

B. BEEBE MEDICAL CENTER

1. Summary of the Evidence

Records obtained from Beebe Medical Center ("Beebe") in response to this investigation indicate that Dr. Bradley applied for appointment to the hospital on November 29, 1993. Those files also make clear that the President of Beebe was aware of the June 24, 1994 Pennsylvania complaint against Dr. Bradley, discussed above, prior to his appointment to the hospital staff. *See* Exhibit 4. That complaint notwithstanding, Beebe appointed Dr. Bradley to its Pediatric Service on July 2, 1994.

In November 1996, Beebe received an internal complaint about Dr. Bradley. The complaint included concerns regarding (1) the number of straight catherizations performed by Dr. Bradley on female patients, (2) comments made by Dr. Bradley with regard to the attractiveness of certain patients' mothers, (3) Dr. Bradley's practice of having only female patients undress for sports physicals, and (4) Dr. Bradley's excessive kissing of little girls.

[37] 67 *Del. Laws* c. 159 § 1 (providing, at section 1731A(d) that "[u]pon receiving reports concerning a licensee, or on its own motion, *the Board shall investigate* any evidence that appears to show a licensee is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine") (emphasis added).

Beebe referred the complaint to another doctor in the hospital for review. *See* Exhibit 5. In January 1997, the reviewing doctor met with Dr. Bradley and discussed the catherization procedures. *See* Exhibit 6. At this meeting, Dr. Bradley set forth his clinical opinions and provided supporting literature for the procedures he performed. The reviewing physician advised Dr. Bradley to have a nurse perform these procedures in the future. With regard to the comments referenced in (2) above, Dr. Bradley indicated that he was being "misunderstood" and the reviewing physician advised him in response to be more cautious concerning such comments in the future. There was nothing in the file produced by Beebe indicating that Beebe investigated or reached any conclusion with regard to complaints (3) and (4) above.

On July 14, 1997, Dr. Bradley submitted a letter of resignation from his position at Beebe as an employed physician on July 14, 1997. In that resignation letter, Dr. Bradley indicated his intention to retain his staff privileges. Dr. Bradley's last day of employment with Beebe was November 14, 1997. In 1998, Dr. Bradley, through counsel, threatened legal action against Beebe alleging that he had been forced to leave his employment with the hospital due to serious false allegations that had been made against him and a conspiracy to force him out. On May 29, 1998, Beebe approved Dr. Bradley to the active staff for two years. The Beebe records contain additional reappointment letters through June 30, 2008.

Handwritten notes from November 12, 1998 in the file produced by Beebe for this report reference a staff complaint about Dr. Bradley. *See* Exhibit 7. The notes, made in response to the threatened litigation, refer to allegations that Dr. Bradley took pictures of children and performed a gynecological exam on a thirteen-year-old patient contrary to the expressed wishes of that patient's mother. There was nothing further in the file produced by Beebe indicating any follow up to these allegations.

In April 2005, while Dr. Bradley maintained privileges at Beebe, the Milford Police Department ("MPD") opened a criminal investigation concerning a reported incident that allegedly occurred at Dr. Bradley's private practice. On April 7, 2005, while the Milford Police Department's investigation of Dr. Bradley was ongoing, an MPD detective delivered an AG's subpoena to Beebe seeking copies of all records of complaints filed against Dr. Bradley and copies of his disciplinary record as part of the criminal investigation. In response, Beebe advised the investigating Milford police officer that it did not have any documents responsive to the subpoena. Counsel for Beebe contacted the DOJ several weeks later and contended that the subpoena request was both overly broad and sought documents protected by the Delaware peer review law and, as a result, Beebe would move to quash the subpoena if the DOJ continued to seek those documents.

In a September 16, 2005 certified letter, Beebe's Vice President of Medical Staff ("VP Medical Staff") wrote to Dr. Bradley about reports of an investigation of his medical practice and reminded Dr. Bradley of his duty to inform Beebe of any activity that may impact the doctor's ability to practice. In a September 19, 2005 memo to the file, the VP Medical Staff documented a meeting with Beebe's President and Chief Executive Officer ("CEO") regarding reports of rumors of inappropriate behavior by Dr. Bradley that had allegedly occurred approximately eight years earlier and that had been investigated by another doctor who found no evidence of wrongdoing. *See* Exhibit 4.[38] Beebe did not keep any records of the investigation.

The September 19 memo further explains that Dr. Bradley denied any knowledge of a current investigation and that any past allegations against him were unsubstantiated. It seems

[38] The September 19 memo, which was produced by Beebe in the course of this investigation, clearly states that Beebe's President was aware of the Pennsylvania complaint against Dr. Bradley prior to Dr. Bradley's appointment to Beebe's staff.

that Dr. Bradley had reported to the VP Medical Staff that he had been the subject of malicious rumors spread by disgruntled employees in the past. The memo concludes that the VP Medical Staff would contact leads to obtain Dr. Bradley's prior records and that Beebe would permit Dr. Bradley to treat patients only if accompanied by a chaperone/witness going forward if there was "any legitimate cause for concern of patient safety."

In a September 21, 2005 certified letter,[39] the VP Medical Staff notified Dr. Bradley that the Delaware Attorney General had conducted or was conducting an investigation of him. *See* Exhibit 8. The letter further documents Beebe's insistence that, pending completion of the criminal investigation, Dr. Bradley be accompanied by a nurse/chaperone at all times while attending any patient at any Beebe facility.

In a September 22, 2005 memo to the file, the VP Medical Staff documented a phone call with Dr. Bradley. *See* Exhibit 9. The note describes the conversation as follows:

> Phone conversation with Dr. Bradley. Informed him of my discovery of the subpoena from April. As we're awaiting a response from the Attorney General's office and the police force, it is the policy of the hospital to mandate that all patient contacts by hand must be in the presence of another witness. He understands this and is very comfortable with this requirement.

Section 1731A(b) places an affirmative obligation on healthcare institutions to report to the BMP any limitations placed on a doctor's staff privileges if the doctor is under "formal or informal" investigation for any reason related to unprofessional conduct. In a sworn statement to the DOJ, the Beebe VP Medical Staff testified that he did not believe that conditioning Dr. Bradley's ability to treat patients on the availability of a chaperone or witness constituted a restriction of Dr. Bradley's practice. The VP Medical Staff based this determination on his review of the

[39] It appears that Beebe sent a second copy of this letter to Dr. Bradley by certified mail on September 28, 2005.

information available on the federal data bank and on internal discussions with Beebe staff and counsel.

In an October 5, 2005 note to the file, the VP Medical Staff documented a phone call with a Milford police detective, during which the detective relayed to the VP Medical Staff that the criminal investigation of Dr. Bradley was closed and no further action was anticipated. The note also indicates that the VP Medical Staff so notified Dr. Bradley.

2. Findings

a. Beebe's 1996 Section 1731A Duty to Report Unprofessional Conduct

Beebe received a complaint about the number of catherizations performed by Dr. Bradley on female patients in 1996. The complaint also raised concerns about comments made by Dr. Bradley to the mothers of patients, Dr. Bradley's practice of having female patients undress for sports physicals, and his excessive kissing of little girls. While Beebe had physicians review the catherization procedures, Beebe made no referral to the BMP concerning the other serious allegations made against Dr. Bradley. Because these above-described complaints, individually and collectively, implicate unprofessional conduct as defined in section 1731(b), we conclude that Beebe failed to fulfill its mandatory duty to report Dr. Bradley in 1996 in violation of section 1731A of the MPA.

b. Beebe's 1998 Duty to Report Unprofessional Conduct Complaints

In 1998, handwritten notes produced by Beebe made in response to threatened legal action by Dr. Bradley summarize the 1996 allegations and memorialize a staff complaint about Dr. Bradley alleging that he was taking pictures of children and performed a gynecological exam on a thirteen-year-old patient contrary to the express intentions of the patient's mother. The complaints that Dr. Bradley took pictures of children, without more, may not rise to the level of

unprofessional conduct. Beebe's knowledge, on the other hand, of the allegation that Dr. Bradley had performed a gynecological exam on a minor patient against the express wishes of that patient's mother, particularly in light of the 1994 Pennsylvania complaint and 1996 information in Beebe's files, created a duty for Beebe to report Dr. Bradley to the BMP for unprofessional conduct in 1998, which it failed to do in violation of section 1731A of the MPA.

c. Beebe's 2005 Duty to Report Restrictions on Privileges

Dr. Bradley maintained staff privileges at Beebe in 2005 while concomitantly engaged in private practice with offices in Milford and Lewes, Delaware. In September 2005, Beebe's Vice President of Medical Staff notified Dr. Bradley about reports of an investigation of his medical practice. Beebe restricted Dr. Bradley's privileges by requiring that his patient contacts take place exclusively in the presence of another person. Under section 1731A(b), limitations of hospital privileges must be reported to the BMP "if the conduct occurs while the person is under formal or informal investigation by the institution or any committee thereof for any reason related to possible unprofessional conduct." There is no evidence, however, that Beebe ever notified the BMP that it had placed restrictions on Dr. Bradley's privileges. Accordingly, we conclude that Beebe failed to report the restrictions it imposed on Dr. Bradley's privileges in 2005 in violation of section 1731A(b) of the MPA.

d. Beebe's Section 903 Duty to Report Suspected Child Abuse

Beebe Hospital is not a "*person*" for purposes of 16 *Del. C*. § 903 and, therefore, is not a mandatory reporter under the child abuse reporting statute.

C. MEDICAL SOCIETY OF DELAWARE

1. Summary of the Evidence

The Medical Society of Delaware ("MSD") is an non-profit association of physicians. The MSD articulates its core purpose as follows: "To guide, serve and support Delaware Physicians, promoting the practice and profession of medicine to enhance the health of our communities." The Physicians' Health Committee ("PHC") is a special committee of the MSD. The Committee's primary mission is: "1) to be of service to physicians with health problems which do or could impair professional functioning, and 2) thereby protect the public from improper health care by impaired physicians. All functions of this committee shall be conducted with a view to improve the quality of medical care as that term is used in 24 Del. C. § 1768."

On October 27, 1999, the PHC and BMP entered into a Memorandum of Understanding ("MOU") that delineated the terms under which each entity operated regarding physicians "in need of evaluation or treatment for a physical or mental impairment and who the committee or the Board has reason to believe may pose a danger to the public health, safety, or welfare or who the committee or the Board has reason to believe may have committed unprofessional conduct." *See* Exhibit 10. By way of example, if a complaint against a doctor implicating his fitness to practice medicine with reasonable skill and safety due to a medical or psychiatric condition was reported to the BMP, *the agency that regulates doctors*, the BMP would refer the doctor to the PHC, *a committee of an association of doctors*, to evaluate and/or examine the doctor and recommend a course of action for treatment.

In 2002, the Delaware General Assembly Joint Sunset Committee ("JSC") questioned whether this arrangement memorialized in the MOU between the BMP and PHC constituted an improper delegation of the BMP's statutory duty to investigate and discipline impaired

physicians to the PHC. The JSC indicated it had an incomplete understanding of the relationship between the MOU and the lack of reports to the BMP required under section 1731A, particularly because the MSD had submitted only one report to the BMP in the prior four years.[40] In part in response to the problems identified by the JSC, the BMP and PHC ceased to operate under the MOU and the General Assembly enacted "Voluntary Treatment Option for Chemically Dependent or Impaired Professionals" legislation in 2005, codified at 24 *Del. C*. § 8735(n) *et seq*. It further enacted section 1731A(h) of the MPA, which purported to amend the MPA to ensure more direct regulation of impaired physicians by the BMP.[41]

Section 1731A(h), however, by its very terms accomplishes no such goal. Instead, it explicitly permits the BMP "*to enter into agreements with others to facilitate its duties under this chapter* . . . ." As a result, under the current MPA, the BMP may not only enter into the very sort of arrangement it did with the PHC in 1999 concerning impaired physicians, it may enter into *any* agreement with *any* party it chooses "to facilitate" *any* of its myriad regulatory duties outlined in Chapter 17, including physician discipline and licensure.

In January 2010, the DOJ subpoenaed records from the MSD for this report. The following information was gleaned from the documents the MSD produced.

On October 21, 2004, Dr. Bradley's sister, Lynda Barnes, faxed a letter to the MSD relating issues of concern regarding her brother. *See* Exhibit 11. The fax trail at the top of that document indicates that the MSD faxed Ms. Barnes' letter to the PHC Chair on November 9, 2004. In a sworn statement to the DOJ, the PHC Chair testified that s/he had no specific recollection of receiving this letter but believes that s/he did receive and read the letter before

[40] *JSC Recommendation Meeting Minutes for BMP Review, April 24, 2002.*
[41] 24 *Del. C*. § 1731A(h).

November 10, 2004. The PHC Chair did not recall being in receipt of the letter at any time prior to November 9, 2004. S/he did, however, testify that, in his/her opinion, nothing in Ms. Barnes' letter was "reportable or remarkable." S/he also stated that when individuals such as Ms. Barnes contact him/her "expressing a concern" about a doctor, she tells them "according to Delaware law, if you feel that a doctor is impaired or may be impaired, you are required to report them to the Board of Medical Practice."[42]

The MSD also produced a fax cover sheet sent by Ms. Barnes to (a) the then-President of the MSD and (b) a PHC member to which Ms. Barnes apparently attached a copy of the October 21, 2004 letter. *See* Exhibit 12. The fax cover sheet reads as follows:

> The following is a copy of the fax I sent to [the PHC Chair] regarding getting help for my brother. We are estranged.
>
> [The PHC Chair] suggested that you might be able to help persuade Dr. Bradley to voluntarily participate in the Impaired Physicians Program, or conversely that you may wish to recuse yourself because you know him. He holds you in the highest regard and respect.
>
> In either case, I have been advised to notify his lawyer that he should contact [the PHC Chair] within the next two weeks for voluntary participation or I will contact the Board of Medical Practice to have his participation required. [The PHC Chair] tells me that under Delaware State Law I am required to report him and that his nurse should have reported him as well. His lawyer also has knowledge of his problems and is so required.
>
> I look forward to speaking with you.

[42] The fact of the matter is, however, that, under the section 1731A of the MPA, it is the PHC Chair, *a licensed medical doctor*, who is required to make reports of physician impairment to the Board of Medical Practice. The lay people to whom the PHC Chair relays this reporting requirement, such as Ms. Barnes, are not mandated to report any such thing to the Board under Delaware law.

It appears that Ms. Barnes sent this fax to the former MSD President on October 21, 2004. A handwritten note on the fax cover page reads: "Calling on advice of [PHC Chair]…Re: concerns in regard to a physician."

The MSD produced a copy of the October 21, 2004 letter from Ms. Barnes in response to a DOJ subpoena. The document produced is a two-page typed letter signed by Ms. Barnes. On the first page of the letter, Ms. Barnes explains that it is her objective to "obtain psychiatric and medical evaluation and treatment for Dr. Bradley in an attempt to help him from destroying his practice and life." The letter proceeds to describe Dr. Bradley's personal and professional problems including his maintenance of poor personal hygiene, failure to complete charts and billing slips, tendency to spend excessive time with patients, accumulation of excessive debt, and habit of engaging in angry outbursts.

The letter then contains a gap in the text approximately 3/4 of an inch. The next readable line after the gap begins with "mood swings." The first page of the letter concludes with Ms. Barnes' description of the condition of Dr. Bradley's house and his relationship with his children. On the second page of the letter, Ms. Barnes opines that an intervention with Dr. Bradley is necessary "before he explodes and further harms his family (a very public collapse or prosecution by parents) or the children in his practice." In closing, Ms. Barnes explains that her brother's spending "has cost him his marriage, the respect of his children and threatens to cost him his practice. I hope that you will be able to intervene in this situation."

The Milford Police Department ("MPD") also produced to the DOJ a copy of a letter that it received from Ms. Barnes in 2005. *See* Exhibit 13. This document appears to be identical to the letter produced by the MSD and described above except it does not contain the 3/4 inch text gap on the first page. Rather, the MPD letter appears to be a complete copy of Ms. Barnes' letter

and reveals that the reported information omitted by the text gap included the following: "accusations by parents of patients that [Dr. Bradley] was handling their daughters with improper touching," accusations that Dr. Bradley was self-medicating for ADD from his sample prescription closet, accusations that Dr. Bradley physically attacked his son and sister, and reports that Dr. Bradley suffered from other physical problems.

In responses to written questions from the State Solicitor, the former President of the MSD stated that he does not recall any specific communications with or receipt of a letter from Ms. Barnes. Moreover, he asserted that he was certain that he had never received any complaint of improper patient conduct with regard to Dr. Bradley. In her sworn statement, the PHC Chair testified that she had never received a complete copy of the letter written by Ms. Barnes (*i.e.*, the version produced by the MPD). The PHC Chair also testified that she would have been obligated to report Dr. Bradley to the BMP had she been aware of the allegations in the complete letter, including the complaint that the doctor had improperly touched female patients.

The DOJ subpoena issued to the MSD also sought any MSD meeting minutes relevant to any complaints concerning Dr. Bradley. The MSD ultimately produced the minutes of a meeting during which the PHC considered the complaint made by Ms. Barnes but only after the MSD unsuccessfully moved the Superior Court to quash the subpoena. The minutes produced are of the PHC's November 10, 2004 meeting, which was held one day after the PHC Chair received Ms. Barnes' letter. *See* Exhibit 14. The minutes provide as follows:

> [The PHC Chair] reported on a call from the sister of a physician who formerly worked in the physician's office, informing of mood swings, depression and extensive credit card debt. The physician is very well respected in the medical community. The sister added that the physician has self-medicated for apparent ADHD and that he is "addicted" to spending. The physician's home is reportedly dirty and cluttered and concern was expressed over the welfare of the children. The physician will likely not be cooperative with any attempt to

> evaluate him. The family has tried unsuccessfully in the past to counsel him. It is the Committee's feeling that it will not be productive to approach the physician and that the matter would best initially be addressed by the [BMP].

It is curious that the PHC Chair discusses Ms. Barnes' allegation that Dr. Bradley was "self-medicating for ADHD" at the November 2004 PHC meeting because, while that information was contained in the complete copy of Ms. Barnes letter produced by the MPD, it was part of the missing text and, therefore, not included in the incomplete copy of Ms. Barnes' letter produced by the MSD.

2. Findings

a. MSD's 2004 Duty to Report Section 1731A Unprofessional Conduct

The MSD disclosed to the DOJ, pursuant to court order, minutes of a November 10, 2004 PHC meeting that MSD initially refused to produce because of the possible application of the medical peer review privilege in 24 *Del. C*. § 1768(b). The minutes of the November 10, 2004 meeting expressly provide that "[i]t is the Committee's feeling that it will not be productive to approach the physician and that the matter would best initially be addressed by [BMP]."

The MSD, however, made no report to the BMP of the complaint against Dr. Bradley it received and reviewed in October-November 2004. Neither the BMP nor the DPR produced any record of any complaint made by the MSD against Dr. Bradley. Moreover, a MSD physician reported to police that s/he had received a complaint from Ms. Barnes concerning Dr. Bradley but did not investigate it because s/he believed it to be "a family matter." It is unclear from the record what specific knowledge Ms. Barnes provided to this doctor with regard to Dr. Bradley.

It is worth noting here that if the MSD had made a report concerning Dr. Bradley to the BMP, it would have resulted in a scenario that best illustrates why the medical licensee mandatory reporting system was broken under the BMP-PHC MOU: that is, once in receipt of

the report of Dr. Bradley, under the MOU, the BMP simply then could refer the matter back to the PHC to evaluate its own complaint. In other words, the MOU reporting system discouraged accountability between the BMP and PHC insofar as investigating allegations of impaired medical licensees was concerned. Moreover, as explained above, the 2005 legislation, which added section 1731A(h) to the MPA, not only makes it lawful for the BMP to enter into these types of MOUs with the PHC, it actually permits the BMP to enter into any agreement it chooses with any party it chooses to facilitate any of its duties under the MPA including physician discipline and licensure. Suffice it to say that such practice retards rather than advances the BMP's duty to protect the public.

That stated, given the information contained in Ms. Barnes' complaint letter and the November 2004 PHC minutes, we conclude that the MSD violated its 1731A duty to report Dr. Bradley to the BMP in 2004. Indeed, the minutes of the November 10, 2004 PHC meeting specifically reveal that the PHC itself determined that the complaint made by Ms. Barnes should be referred to and addressed by the BMP. Nonetheless, the MSD failed to make any report to the BMP concerning the unprofessional conduct Ms. Barnes' alleged Dr. Bradley had committed in her communications with the MSD.

b. <u>MSD's Section 903 Duty to Report Suspected Child Abuse</u>

The MSD is not a "person" for purposes 16 *Del. C*. § 903 and, therefore, is not a mandatory reporter under the child abuse statute.

c. <u>Individual MSD Physicians' Independent Section 1731A Duty to Report Unprofessional Conduct</u>

In addition to the MSD as an entity, the individual MSD physicians, including the chair of the PHC, each has a duty to report suspected unprofessional medical licensee conduct to the

BMP under section 1731A. Each also has a duty to report to the Board information s/he reasonably believes indicates that a medical licensee "may be unable to practice medicine with reasonable skill or safety to patients by reason of mental illness or mental incompetence; physical illness, including deterioration through the aging process or loss of motor skill; or excessive use or abuse of drugs, including alcohol" under section 1731A(a). As a result of the information provided to the MSD in its review of Ms. Barnes' 2004 complaint concerning Dr. Bradley, including allegations that Dr. Bradley was self-medicating for ADHD, had a self-destructive "addiction" as well as Ms. Barnes statement that she was "concerned for the welfare of the children," we conclude that the PHC Chair, *as well as all MSD physicians with similar knowledge concerning Dr. Bradley*, failed to comply with their independent duty to report Dr. Bradley to the BMP in violation of section 1731A.

d. Individual MSD Physicians' Independent Section 903 Duty to Report Suspected Child Abuse

The MSD physicians, including the chair of the PHC, each are also mandatory reporters of child abuse under 16 *Del. C*. § 903. It appears, however, that neither the PHC Chair nor any other MSD physician had an obligation to report Dr. Bradley under section 903 based on the content of the complaint document produced by the MSD, which does not detail any accusations of child abuse against Dr. Bradley.

D. MILFORD POLICE DEPARTMENT

1. Summary of the Evidence

On March 30, 2005, the mother of one of Dr. Bradley's minor patients contacted a Milford Police Department ("MPD") officer. This mother (Witness 1) advised the investigating officer by phone that she had gone to Dr. Bradley's office, Bay Bee's Pediatrics in Milford, on

the previous day for an appointment with her one-year-old son. She had brought her three-year-old daughter to the office visit as well. Upon completion of his examination of her son, Dr. Bradley asked the mother if he could give a lollipop to the three-year-old girl. The mother replied yes and then began to put on her son's coat. As she turned around, the mother realized that Dr. Bradley had left the room with her daughter. According to the mother, Dr. Bradley and her daughter were gone for a couple of minutes and, when they returned, her daughter had a lollipop. Once the family left the doctor's office, the daughter asked her mother "why the doctor kissed her tongue?" As a result of this report, the MPD officer scheduled the complainant's daughter for a Kent County Children's Advocacy Center ("CAC") interview the following day, March 31, 2005.

During the CAC interview, the three-year-old patient was reluctant to discuss the trip to the doctor's office. She explained that Dr. Bradley had kissed her but not on her cheek or nose. When the forensic interviewer asked the three-year-old where Dr. Bradley had kissed her, she refused to answer, appeared to become embarrassed and began to ask for her mother. Ultimately, the CAC interviewer left the room and the patient's mother entered the interview room with her daughter. Subsequent to additional questioning by her mother, the three-year-old stated that that Dr. Bradley had "licked her on her tongue" and she then proceeded to show her tongue. A DOJ Deputy Attorney General attended the CAC interview and assisted the MPD investigation.

After the CAC interview, the MPD officer interviewed a number of additional witnesses who are identified by witness number in the police report. *See* Exhibit 15. The third witness (Witness 3) MPD interviewed was a pediatrician who had practiced previously with Dr. Bradley. Witness 3 stated that s/he and Dr. Bradley had worked together when they both first began

practicing in Delaware. Witness 3 relayed that s/he "has referred to [Dr. Bradley] as a pedophile when talking to colleagues." S/he further indicated that s/he knew of three of his/her current patients who were former patients of Dr. Bradley and who had reported to him/her that Dr. Bradley "conduct[ed] long vaginal exams on female patients." Witness 3 advised the father of one of the patients that a long vaginal exam "was not normal."

The fourth witness (Witness 4) MPD interviewed was also a Lewes-area doctor. S/he had worked with Dr. Bradley for approximately eight months. Witness 4 described Dr. Bradley as a "different character" who is "careless in the way he handles children." Witness 4 had never observed inappropriate behavior by Dr. Bradley but s/he did report that s/he has had patients switch to his/her practice because Dr. Bradley had performed female examinations on those patients. Moreover, s/he had heard reports of Dr. Bradley forcing female patients to get undressed against their wishes and removing patients from their parents for several minutes. Witness 4 explained that Dr. Bradley had a "hobby" of taking digital pictures of patients in his office and then manipulating those images on his computer, for example, by putting the patient's head on "Elmo's" body. Witness 4 believed that there had been complaints regarding Dr. Bradley filed at Beebe Hospital that involved allegations of sexual conduct, poor communication, and lapses in care.

Witness 9 took his/her daughter to Dr. Bradley for a well visit around 2000. During the exam, Dr. Bradley's face was close to her daughter's vagina and he pulled down her pants, parted her labia, and put his finger insider her. Witness 9's daughter then screamed, which caused Witness 9 to jump from where s/he was seated during the examination. Witness 9 asked Dr. Bradley what he was doing and Dr. Bradley stated that he was checking his/her daughter's

hymen. Witness 9 was very upset with Dr. Bradley and never returned to the office. She indicated that s/he had never observed any other pediatrician perform this type of examination.

Another witness police interviewed was the grandparent of a former Dr. Bradley patient. In July 2003, this witness took his/her then-seven-year-old granddaughter for an exam at Dr. Bradley's office. During the exam, Dr. Bradley asked the seven-year-old patient to pull down her underwear, and "he then spread her vagina open with his hand." This witness initially turned away but, upon perceiving that his/her granddaughter was "getting out of control," s/he told Dr. Bradley "that's enough" and he stopped. After the exam, this witness questioned why Dr. Bradley had inspected her granddaughter's vagina and he replied that it was part of the exam. This witness never returned to Dr. Bradley's office

MPD also interviewed Dr. Bradley's sister, Ms. Barnes, who had served as Dr. Bradley's office manager for three years. Dr. Bradley fired Ms. Barnes on August 12, 2004 due to their conflicts. Ms. Barnes reported to police that Dr. Bradley exhibited problematic behavior including spending excessively and abusing medication samples. She related that Dr. Bradley had been reported approximately fifteen years earlier to Pennsylvania Child Protective Services for beating his then-four year old son. She also reported that Dr. Bradley prescribed diabetic medication for a cousin in Philadelphia who would have the prescription filled and then give the medication to Dr. Bradley. She further alleged that Dr. Bradley engaged in such behavior to ensure his insurance provider would not discover that he was diabetic.

Ms. Barnes also told police that she received several complaints from parents that Dr. Bradley had improperly touched their children. She explained that Dr. Bradley "would pick up girls and have his hand under their clothing." Ms. Barnes kept private notes concerning these issues but could not locate those notes after she was fired. She conveyed that one parent refused

to let Dr. Bradley see her older daughter because the parent felt that the doctor kissed that child too much. Ms. Barnes further informed police that, approximately sixteen years ago, Dr. Bradley's uncle, William Arthur Bradley, had been arrested for pedophilia at Pennsylvania State College. She also stated that Dr. Bradley's father showed signs of pedophilia and that police had found child pornography in his home.

During her interview, Ms. Barnes explained that she wrote a letter to the Medical Society of Delaware enumerating her concerns about Dr. Bradley. She wrote the letter to the MSD in an attempt to seek a psychiatric and medical evaluation of, as well as treatment for, Dr. Bradley. Ms. Barnes stated that she sent the letter to the PHC Chair who then turned it over to the President of the MSD for investigation. Ms. Barnes also stated that she spoke with the then-MSD President about Dr. Bradley. According to Ms. Barnes, that doctor relayed to her that Dr. Bradley appeared to have the same type of problems that she had reported on his record from Philadelphia. As noted previously, the Milford Police Department produced to the DOJ a complete copy of the November 9, 2004 letter sent from Ms. Barnes to the MSD.

MPD also interviewed a Lewes-area doctor who served, at the time of the interview, as the President of the MSD. This witness informed MPD that s/he had received a complaint from Dr. Bradley's sister but considered the concerns Ms. Barnes raised "a family matter" and, as a result, did not investigate them. S/he also explained that the nurses at Beebe regarded Dr. Bradley as one of the best pediatricians with whom they worked at the hospital. This witness recalled a complaint concerning sexual abuse by Dr. Bradley that had been reported in Philadelphia but was of the opinion that it was an attempt to extort money from Dr. Bradley.

On March 31, 2005, the criminal prosecutor assigned to the Dr. Bradley investigation ("DAG-Prosecutor") notified a DOJ social worker about the CAC interview of Witness 1's

daughter by e-mail. The DAG-Prosecutor also notified his immediate supervisor ("DAG-Supervisor") and the State Prosecutor of the case by e-mail. On April 4, 2005, the DAG-Prosecutor sent a series of e-mails to ascertain the name of the Deputy Attorney General assigned to represent the Board of Medical Practice (DAG-Medical Board).

In a sworn statement, the DAG-Prosecutor stated that he may have contacted the DAG-Medical Board. The DAG-Medical Board, in turn, recalled a short phone conversation between himself, the DAG-Prosecutor and DAG-Supervisor. According to the DAG-Medical Board, during that phone conversation, the criminal prosecutors discussed with him a complaint against a downstate doctor who was alleged to have kissed a child. The DAG-Medical Board indicated that he "thought they'd have a difficult time . . . getting a conviction" on the allegation that a doctor kissed a patient. The DAG-Medical Board believed that it would be a challenge to obtain either a criminal conviction or a finding of unprofessional conduct by the BMP on the basis of the information provided to him by the criminal prosecutors.

In his interview, the DAG-Supervisor reported that he had no recollection of any direct involvement with the Dr. Bradley case beyond being copied on two e-mails. The DAG-Supervisor was on vacation in late March 2005 when the case was first reported to the DOJ.

On May 23, 2005, the DAG-Prosecutor contacted the Milford police detective investigating Dr. Bradley by e-mail and relayed that he would discuss the case with the State Prosecutor. Also, on May 23, 2005, the DAG-Prosecutor wrote an e-mail to the State Prosecutor explaining the reasons why he believed that he should decline prosecution of the case. *See* Exhibit 16. In that e-mail, the DAG-Prosecutor informed the State Prosecutor that the police had uncovered several complaints about inappropriate medical examinations conducted by Dr.

Bradley from doctors, patients and Dr. Bradley's sister. He also relayed that at least one doctor believed that Dr. Bradley was a pedophile.

The DAG-Prosecutor, however, did not believe that that State could meet its burden of proof in a criminal case based on the evidence obtained by MPD.[43] Among other things, the DAG-Prosecutor noted that he could not prove a criminal case against Dr. Bradley because Witness 1's daughter was only alone with Dr. Bradley for a very short time during which her mother was in an adjacent room. In conclusion, the DAG-Prosecutor recommended "that some kind of civil action such as a referral to the medical practice board would be more appropriate."

In a reply e-mail sent on May 23, 2005, the State Prosecutor indicated that he would defer to the DAG-Prosecutor's decision not to prosecute Dr. Bradley. The State Prosecutor also asked the DAG-Prosecutor to run the case by the then-State Solicitor before concluding the investigation and to advise him of what transpired. There is no indication in the records reviewed for this compliance review that the then-State Solicitor was contacted by anyone regarding the Dr. Bradley investigation.

In a handwritten note dated May 25, 2005, the DAG-Prosecutor documented that he had spoken with the investigating Milford detective and the detective had concurred that there was

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[43] Rule 3.8 of the Delaware Lawyers' Rules of Professional Conduct, adopted by the Delaware Supreme Court

> In 1985, requires a prosecutor to "refrain from prosecuting a charge that the prosecutor knows is not supported by probable cause." Both the American Bar Association and the National District Attorneys Association have explained that only evidence that is believed to be admissible at trial is to be considered
>
> when determining whether a prosecution should be initiated. See, e.g., *Task Force: Prosecution Function and Def. Standards,* Am. Bar Ass'n*, ABA Standards for Criminal Justice: Prosecution Function and Defense Function* Standard 3-1.1 (1993); National District Attorneys Association*, National Prosecution Standards Background* (1991)

insufficient evidence to prosecute Dr. Bradley. *See* Exhibit 17. The note also states that the Milford detective "will contact the Med. Practice Bd. with this [Dr. Bradley] complaint." A June 6, 2005 CAC Follow-Up Notification Form states that the DOJ declined prosecution of the case on June 1, 2005. In a September 15, 2005 handwritten note to the file, the DAG-Prosecutor wrote: "This case was referred to the Medical Practice Board by Milford P.D. We decided not to prosecute because there was not enough evidence."[44]

On June 10, 2005, the Milford police detective investigating Dr. Bradley filed a supplement investigative report. *See* Exhibit 18. In that report, the detective noted that the DOJ prosecutor assigned to the case had decided not to prosecute Dr. Bradley after reviewing the evidence with his supervisors. According to the detective, the assigned prosecutor intended to contact the Deputy Attorney General who represented the BMP to provide notice of the allegations against Dr. Bradley. In his supplemental report, the Milford detective also noted that he had contacted a DPR investigator about the case. According to the detective, the DPR investigator told him "to have the victim and any other witnesses file a complaint with the medical board." The Milford detective further relayed on his supplemental report that he contacted Witness 1 and Ms. Barnes and advised both of those witnesses how to contact the BMP.

In a sworn statement, the Milford police detective recalled that a DPR investigator had told him that DPR did not take complaints from the police. The DPR investigator, on the other

[44] While not germane to this report, generally, witnesses who can only testify to a person's overall bad "character" are prohibited from doing so. In addition, "other acts" evidence is severely circumscribed under the rules of evidence. *Getz v. State*, 538 A.2d 726 (Del. 1988). Finally, the victim in this particular case would not discuss what happened except when she was unaware people could see her. It is at least an open question whether she would have qualified to give any statement at all.

hand, testified that he did not recall any specific conversation with the Milford police detective about the Dr. Bradley investigation. The DPR investigator also stated that if he had received a complaint about a doctor, he would have instructed the complainant to put it in writing and that either the police officer or the victim could have filed a complaint.

2. Findings

a. Licensed Physicians' Duty to Report: Witness 3

i. Duty to report section 1731A unprofessional conduct

As detailed above, Witness 3, who is a physician, worked in the same practice as Dr. Bradley for some time. Witness 3 reported to police that s/he referred to Dr. Bradley as a pedophile when talking to colleagues. More significantly, Witness 3 informed the police that three of his/her female patients, who were former Dr. Bradley patients, reported that they had stopped seeing Dr. Bradley because he conducted long vaginal examinations on them. Accordingly, we conclude Witness 3 failed to satisfy his/her affirmative duty to report Dr. Bradley to the BMP in violation of section 1731A.

ii. Duty to report section 903 suspected child abuse

The nature of the patients' vaginal examinations conducted by Dr. Bradley and known to Witness 3 may have also triggered an obligation on the part of this doctor to report Dr. Bradley pursuant to 16 *Del. C*. § 903 for good faith suspicion of child abuse.

b. Licensed Physicians' Duty to Report: Witness 4

i. Duty to report section 1731A unprofessional conduct

As detailed above, Witness 4, a physician, described Dr. Bradley as different and careless in the way he handled children. Witness 4 treated former female patients of Dr. Bradley several of whom had reported to Witness 4 that they had transferred from Dr. Bradley due to the nature

of Dr. Bradley's examinations. Witness 4 had been informed that Dr. Bradley had a practice of forcing female patients to get undressed and of taking children from their parents for long periods of time. Witness 4 also reported that Bradley took pictures of his minor patients and manipulated those pictures on the computer. The unprofessional conduct reported to Witness 4 by Dr. Bradley's former female patients triggered Witness 4's affirmative duty to report Dr. Bradley to the BMP. Nonetheless, Witness 4 failed to report Dr. Bradley in violation of section 1731A.

ii. Duty to report section 903 suspected child abuse

The lack of specificity with regard to Witness 4's description of the vaginal examinations Dr. Bradley conducted on those patients, however, likely does not satisfy the criteria of abuse under 16 *Del. C.* § 902(1) and, thus, did not trigger a duty to report child abuse under section 903.

c. Law Enforcement's Duty to Report: Overview

i. Duty to report section 1731A unprofessional conduct

Two items are worth noting here. First, as explained in the applicable law section of this report, law enforcement agencies are vested with an investigatory privilege under Delaware law that permits them to maintain the secrecy of a criminal investigation during its pendency and that privilege arguably trumps law enforcement's section 1731A duty to report any reasonable belief of unprofessional conduct on the part of medical licensee at least until the conclusion of a criminal investigation. Second, law enforcement agencies exclusively investigate crimes and the duty to report *criminal* "unprofessional conduct" to the BMP is not triggered under 24 *Del. C.* § 1731(b)(2) until a medical licensee either has been convicted of or has plead guilty to a crime substantially related to the practice of medicine. As such, a law enforcement agency's duty to

report unprofessional conduct to the BMP arguably is not triggered until it has obtained a conviction of or a guilty plea from a medical licensee pursuant to section 1731(b)(2).

That stated, for purposes of this report, we will interpret the language of section 1731A literally and broadly. As a result, we assume, *arguendo*, that law enforcement agencies have a duty to report any and all "unprofessional conduct" under the section 1731(b) of the MPA notwithstanding the fact that those agencies lack the medical training and expertise to have a good faith "reasonable belief" that a medical licensee has committed "unprofessional conduct" under the overwhelming majority of examples provided in section 1731(b). In the final section of this report, we recommend a legislative change to the MPA to address this ambiguity, which, if not amended, could result in public safety issues.

d. Law Enforcement's Duty to Report: Milford Police Department

i. MPD's duty to report section 1731A unprofessional conduct

The Milford Police Department ("MPD") investigated Dr. Bradley in 2005. MPD initiated the investigation upon its receipt of a complaint from the parent of one of Dr. Bradley's female patients. That parent reported to MPD that Dr. Bradley kissed her daughter on the tongue during an office visit. Throughout the course of the 2005 Dr. Bradley investigation, MPD conducted numerous interviews and worked closely with the DOJ. At the conclusion of the investigation, the DOJ determined that a prosecution of Dr. Bradley could not be maintained.

The MPD supplemental police report clearly states that, after the DOJ declined to prosecute Dr. Bradley, the investigating MPD detective contacted a Division of Professional Regulation ("DPR") investigator who told the detective to have the victim and any other witnesses file a complaint with the BMP. The MPD detective further noted that he contacted

both Dr. Bradley's sister and the parent who reported that Dr. Bradley had kissed her daughter on her tongue to explain to them how to report Dr. Bradley to the BMP.

We conclude that MPD had an affirmative duty to report to the BMP that Dr. Bradley had engaged in unprofessional conduct under section 1731A. Although the criminal matter did not result in a charge or arrest, let alone a conviction, an MPD detective nonetheless took reasonable steps to contact a DPR investigator by phone concerning the allegations against Dr. Bradley. Thus, MPD substantially complied with the reporting requirements of section 1731A. We acknowledge that MPD was required to report Dr. Bradley to the BMP *in writing* pursuant to section 1731A and the BMP has no duty to investigate a complaint it receives pursuant to section 1731A unless it is made *in writing* and *identifies the complainant*.[45] The BMP Executive Director, however, is vested with the statutory authority to investigate an oral complaint so long as the complainant is identified.[46] Thus, the BMP could have investigated Dr. Bradley based on the verbal report provided by the MPD detective in 2005.

ii. MPD's duty to report section 903 suspected child abuse

Because the MPD is a municipal law enforcement agency, it is not a mandatory reporter under 16 *Del. C*. § 903, the child abuse reporting statute. The investigating MPD detective, on the other hand, is a mandatory reporter under section 903. The section 903 reporting requirements are governed by rules promulgated by the Division of Child Protective Services. Rule F-9 regarding Child Sexual Abuse provides: "The Division accepts reports of extrafamilial child sexual abuse *only* to ensure that the appropriate police agency is notified. If police have not been notified, the Division will notify the appropriate police jurisdiction." (Emphasis added).

[45] 24 *Del. C*. § 1733(b).
[46] *Id*. § 1733(c) ("The Executive Director may also investigate an unwritten complaint at the Executive Director's own discretion, provided the complaining party is identified.").

The Division's regulations specifically address "Extrafamilial Child Abuse" at Rule F-11:

> When a report of maltreatment is received involving a child from birth to 18 years of age in which the maltreator is not the parent, caretaker, or child care facility, the reporter will be instructed to notify the appropriate law enforcement authority. If the reporter is unwilling or when the Division is unsure if the reporter will contact police, the Division shall make the report to the police.

Because the report concerning Dr. Bradley was made to MPD by a parent of one of Dr. Bradley's minor patients and MPD promptly conducted an investigation into the complaint, there is no reasonable basis to conclude that the MPD officer failed to comply with the reporting requirements of section 903. The rules governing such reporting only require that the Division contact the law enforcement agency and not vice versa.

e. Law Enforcement's Duty to Report: Delaware Department of Justice

i. DOJ's duty to report section 1731A unprofessional conduct

The Delaware Department of Justice ("DOJ") worked in concert with the MPD during the 2005 Dr. Bradley investigation. When the DOJ declined prosecution, the criminal investigation was closed. At that point, the record reveals that the prosecuting attorneys in the Criminal Division exchanged information about the case through conversations and e-mail. Those communications indicate that, while prosecutors concluded there was not enough evidence to proceed with criminal charges against Dr. Bradley, they nonetheless should have reported the serious allegations of misconduct in the practice of medicine made against Dr. Bradley in the criminal investigation to the BMP. The DOJ relied on a MPD officer to make the report to the BMP and then failed to verify that any such report was properly made. Having concluded that each law enforcement agency has an independent duty to report, the DOJ violated its mandatory reporting obligation in violation of section 1731A.

As explained previously, under section 1731A, it is the DOJ—and not the individual DAGs—that has a duty to report. In 2005, the DOJ had no written policy to guide DAGs with respect to the agency's section 1731A reporting requirements. The DOJ now has in place written guidelines outlining the mandatory reporting obligations of the office and individual DAGs. *See* Exhibit 19.

ii. DOJ's duty to report section 903 suspected child abuse

Because the DOJ is a law enforcement agency, it is not a mandatory reporter under 16 *Del. C*. § 903. As discussed above, to the extent that any individual prosecutor learned of any allegations of child abuse from the MPD, the Division of Child Protective Service's reporting requirements concerning extrafamilial child abuse only provide for police notification. Therefore, where, as here, law enforcement was notified and conducted an investigation concerning the allegations against Dr. Bradley, individual prosecutors had no duty to report under section 903.

D. MINOR PATIENTS' PARENTS AND GUARDIANS

This compliance review does not find any reasonable basis to conclude that the parents or guardians of any of Dr. Bradley's minor patients violated Delaware's mandatory reporting laws. First, neither parents nor guardians are mandatory reporters under 24 *Del. C.* § 1731A and, as a result, those individuals cannot commit section 1731A violations. Second, because the parents and guardians at issue in this review reported Dr. Bradley's conduct to the police consistent with 16 *Del. C*. § 903, there is no basis to find that those individuals violated section 903.

E. LIMITATIONS PERIOD FOR SECTIONS 1731A AND 903 VIOLATIONS

As discussed in the applicable law section of this report, the Board likely lacks jurisdiction to enforce section 1731A. Regardless of whether jurisdiction properly lies, in the

absence of any regulatory provisions to the contrary, the applicable civil penalties for section 1731A violations are subject to a three-year statute of limitations period. 10 *Del. C.* § 8106.[47] All possible charges of failure to comply with sections 1731A mandatory reporting obligations that we reviewed in this compliance report relate to events that occurred in 2005. As a result, we are barred by the statute of limitations from commencing any civil prosecutions notwithstanding our findings above that certain individuals and entities failed entirely to comply with section 1731A.

Prior to 2009, failure to report child abuse under section 903 constituted a criminal misdemeanor for which the applicable statute of limitations was two years. 11 *Del. C.* § 205. As discussed earlier, the penalty for failure to report child abuse was amended from a criminal to a civil penalty by the General Assembly in 2009. Accordingly, the statute of limitations for any possible criminal misdemeanor under section 903 had run before the enactment of the civil penalties in 2009 and, therefore, prosecution of any section 903 violation committed in 2005 is barred by law notwithstanding our findings above.

We have elected to maintain the anonymity of many of the mandatory reporters in this report. The statute of limitations for violations of the mandatory reporting obligations has run and conclusions are made in many cases without giving the reporters an adequate opportunity to rebut the conclusions. This is a public report–necessarily so–intended to assist government

[47] *Johnson v. Williams*, 728 A.2d 1185, 1188-89 (Del. Super. 1998); *see also Kotler v. Bd. of Med. Practice*, 630 A.2d 1102 (TABLE), 1993 WL 307621, at *3 (Del. Jul. 29, 1993) (statute of limitations applies to administrative disciplinary proceedings except proceedings to suspend or revoke a license to practice medicine); *Bash v. Bd. of Med. Practice*, 579 A.2d 1145, 1152 (Del. Super. 1989). As *Kotler* and *Bash* explain, the statute of limitations applies to Board of Medical Practice proceedings except proceedings to suspend or revoke a medical license. Section 1731A is not a basis to revoke or suspend a medical license, accordingly, the statute of limitations, and not administrative laches, applies to section 1731A proceedings. We propose a resolution to address this problem in our recommendations section of this report.

policy makers protect the public from criminally dangerous physicians. While we must expose certain failures in the current system by reference to specific facts and circumstances this is not a court of law, which is the only entity that may pronounce guilt in our system of jurisprudence.

IV. RECOMMENDATIONS

The noted lack of compliance with the mandatory reporting requirements of 24 *Del. C*. § 1731A and 16 *Del. C*. § 903 during the time period pertinent to this review suggests systemic failures in the reporting process. The DPR reports that, of the 314 complaints of unprofessional conduct made to the BMP over the last decade, 2000-2010, thirty-one (31) were filed by doctors; twenty-seven (27) were filed by other health care providers; six (6) were filed by the Medical Society; and thirteen (13) were filed by health care institutions. Law enforcement agencies only filed four (4) section 1731A reports during this ten-year reporting period. Other State agencies filed the remaining 233 complaints, most of which consisted of reports filed by the courts concerning medical malpractice lawsuits against doctors. Neither the DPR nor the BMP have any record of any complaint ever filed by any individual or entity against Dr. Bradley.

In January 2010, DPR sent letters to all section 1731A mandatory reporters reminding them of their reporting obligations under section 1731A. Since that time, DPR has experienced a substantial increase in the receipt of unprofessional conduct complaints against doctors. For example, DPR only received approximately one hundred (100) unprofessional conduct complaints against medical doctors in calendar year 2009. By comparison, in calendar year 2010, DPR had received forty-five (45) complaints against physicians by mid-March.

Of the 314 complaints filed during the same ten-year period mentioned above, 2000-2010, the BMP revoked the licenses of fourteen (14) medical doctors. In six (6) of those fourteen cases, the Delaware-licensed physician misconduct prompting revocation occurred in another state. Of the eight (8) cases involving Delaware-licensed physician misconduct that occurred in Delaware, five (5) included criminal convictions and one (1) involved pending criminal charges. In addition to the fourteen revocations, the BMP issued four (4) suspension

orders over the last decade (not counting interim suspension orders of doctors whose licenses the BMP ultimately revoked). Of those four suspensions, two involved Delaware-licensed physician misconduct committed in Delaware for failure to comply with continuing education requirements. A third involved Delaware-licensed physician misconduct committed in New Jersey involving controlled prescriptions, patient care, and record keeping violations. The fourth involved Delaware-licensed physician misconduct committed in Pennsylvania including permitting an unlicensed person to administer controlled substances and prescription medication to patients and to perform medical examinations of patients and maintaining a clinic in a deplorable and unsanitary condition.

By contrast, during the 2000-2010 period, both law enforcement and the medical community reported extensively to the child abuse hotline maintained by the Delaware Department of Services for Children, Youth and their Families ("DSCYF") pursuant to 16 *Del. C.* § 903. For example, law enforcement agencies made 1480 reports in FY 2005 alone. Similarly, the medical community made 500 reports in FY 2005. These statistics strongly suggest that that medical and law enforcement agencies are much more familiar with and adept at reporting 16 *Del. C.* § 903 violations to the DSCYF child abuse hotline than reporting 24 *Del. C.* § 1731A violations to the BMP.

The reasons for this are surely many and varied. We do note one, however, that may not be readily apparent. The law that mandates reporting of physician unprofessional conduct is found in Title 24 of the Delaware Code, which regulates "Professions and Occupations." Title 24 is simply not an area that law enforcement or criminal prosecutors deal with on a daily basis. In those rare cases reported to the Board by law enforcement, there is every reason to believe that the reports were made by organizations that were ignorant of the reporting duty but reported only

because it occurred to them that it could be done. We have found no training or other materials advising law enforcement of the Title 24 duty to report.

The law that mandates reporting of child abuse, by contrast, is found in Title 16, which regulates "Health and Safety." Title 16 also regulates child abuse and controlled substances including illegal narcotics. Thus, there is no doubt that law enforcement generally is more familiar with Title 16. That stated, DSCYF reported that no complaints were ever filed against Dr. Bradley pursuant to 16 *Del. C*. § 903.

Delaware has consistently followed and adopted national standards and model statutes with regard to mandating the reporting of medical licensee misconduct. As outlined in detail above, these standards and model acts obviously are not without flaw. Based on the evidence gathered in this investigation and our examination of the law, the following recommendations to improve the medical licensee mandatory reporting processes are proposed:

1. Eliminate the BMP's Authority to Enter into Agreements with other Entities to Investigate and Discipline Licensees – *Statutory Change Required*

As explained previously in this report, from approximately 1999 to 2004, the BMP agreed, pursuant to an MOU to defer the investigation and discipline of impaired medical doctors to the PHC, a committee of physicians under the auspices of the Medical Society of Delaware, the physicians' trade association. The JSC criticized this arrangement as an unlawful delegation of the power from the BMP to the PHC. Nevertheless, in 2005, 24 *Del. C.* § 1731A(h) was added to the MPA, which retains for the Board the power to "enter into agreements with others to facilitate its duties under this chapter . . . ." Indeed, in 2005, when the information then known to numerous mandatory reporters should have been reported to BMP, it is entirely likely that, upon notification, the Board would have referred the matter to the PHC of the Medical

Society, one of the very entities that failed to report in this case despite its *subjective* awareness of its duty to do.

As this report makes clear, the Board should have been notified of the complaints that were circulating regarding Dr. Bradley's behavior in 2005. Had such a report been made, we believe that DPR would have been required to initiate an investigation. In any event, in 2006 the Board's statute was amended to require that the Executive Director of the Board review all reports made pursuant to section 1731A *before* the DPR or the Board takes any action. Further, the Executive Director was empowered to defer any investigation into such a report, pending a reported licensee's evaluation and treatment for substance abuse or physical or mental illness. Only upon the completion of the reported licensee's evaluation and treatment may the Executive Director resume investigation. If the Executive Director determines that deferral of an investigation is warranted, the matter is summarized and placed before the BMP "for its information."

While the Board taking or deferring action on a licensee in need of treatment does not appear to be problematic, it is not prudent to allow the Board to delegate to a committee of the Medical Society of Delaware the appropriate handling of an impaired physician. Worse yet, as previously explained, the 2005 MPA legislation, which added section 1731A(h) to the MPA, not only makes it lawful for the BMP to enter into these types of MOUs with the PHC, it actually permits the BMP to enter into any agreement it chooses with any party it chooses to facilitate any of its duties under the MPA including physician discipline and licensure. Such practice allows the BMP to delegate its duty to protect the public by imposing discipline on incompetent and unprofessional doctors to doctor-protective and other organization that have no responsibility to answer to the public. The MPA should be amended to remedy this deficiency.

2. Clarify the BMP's Ability to Withhold Prompt Notice of a Complaint to a Licensee Where Either a Criminal Investigation or Public Safety May Be Compromised – *Statutory Change Required*

Under the current MPA, the Board of Medical Practice must "promptly acknowledge" to complainants "all reports received" under section 1731A. 24 *Del. C.* § 1731A(e). Moreover, pursuant to section 1733(a)(2), "[t]he [BMP] Executive Director shall acknowledge to the complainant in writing receipt of the complaint *within 1 week of receiving the complaint*, and shall advise the complainant of the progress of the case at least every 90 days until the case is resolved." (Emphasis added). As a matter of practice (and not due to any provision of the MPA), the BMP also sends notice of the complaint (often including the identity of the complainant) to the respondent medical licensee at the same time it acknowledges receipt of that complaint to the complainant, *i.e.*, "*within 1 week*." This procedure generally ensures that a respondent medical licensee is noticed that DPR is conducting an investigation into that licensee's conduct well before DPR has had the opportunity to complete a thorough investigation of the complaint. Such practice is highly disfavored by law enforcement agencies, which routinely conduct criminal investigations of suspects confidentially to ensure that suspects are not noticed of those investigations before they are concluded and, thus, lack incentive to intimidate witnesses, flee the jurisdiction or destroy evidence. That stated, the MPA and 29 *Del. C.* § 8735 should be amended to prevent the BMP from noticing the respondent licensee that a complaint has been filed if such notice would (1) compromise or interfere with an on-going criminal investigation or (2) otherwise impose a risk to public health or safety.

3. Clarify Law Enforcement Agencies' Section 1731A Duty to Report – *Statutory Change Required*

As explained previously in this report, a broad interpretation of section 1731A mandates law enforcement agencies report any and all suspected "unprofessional conduct" committed by a medical licensee. Imposing on law enforcement such a broad duty to report is untenable. Whether the majority of the medical licensees' conduct regulated by the BMP is "unprofessional" under section 1731(b) is well beyond the purview of most police officers and law enforcement agencies, none of which are required to have any specialized training or expertise with regard to medical practice standards. Moreover, law enforcement agencies are vested with an investigatory privilege that entitles those agencies to conduct criminal investigations confidentially and without notice to the target in order to mitigate a suspect's ability to interfere with the criminal investigation. The important right of law enforcement to invoke the investigatory privilege during a criminal investigation directly conflicts with section 1731A's mandate that law enforcement agencies report to the BMP any "reasonable belief" that a medical licensee has committed "unprofessional conduct" within 30 days of that agency's receipt of such information. Accordingly, the MPA should be amended to acknowledge the investigatory privilege that law enforcement agencies may invoke during the pendency of a criminal investigation as well as specifically and clearly articulate when a law enforcement agency's duty to report is triggered. One potential means of accomplishing this recommendation would be to amend the MPA to state that law enforcement agencies be required to report any "reasonable belief" of "unprofessional conduct" committed by a medical licensee within 30 days of the close of a criminal investigation or upon arrest of a medical licensee. Further, the law enforcement agencies' mandatory reporting requirement should be limited to criminal

investigations and arrests and not the much broader and far reaching incidences of unprofessional conduct addressed by the Code.

4. Clarify Jurisdictional Issues with Regard to Non-Licensee Section 1731A Mandatory Reporters – *Statutory Changes Required*

Under the current MPA, the enforcement jurisdiction over several of the entities (*i.e.*, hospitals, law enforcement agencies, state agencies) enumerated as mandatory reporters under section 1731A is unclear. Although 24 *Del. C*. § 1713 ("Powers and Duties of the Board") makes no mention of any power or duty with respect to private or public agencies, section 1731A gives the Board the power to impose fines on both private and public agencies (the mandatory reporters of section 1731A(a)(1-6)) for violating the duty to report. While the power to impose fines may be inferred from 24 *Del. C*. § 1713(a), which declares that the Board has the powers enumerated therein "in addition to other powers and duties set forth elsewhere in this chapter," the issue is hardly clear. As stated in this compliance report, the DPR in its comments to the legislative sunset committee stated that the Board has no power over hospitals and other mandatory reporters. Section 1731A should be clarified to expressly state the Board has jurisdiction to impose civil penalties for failure to report on these entities.

The second anomaly in the reporting statute is section 1731A(i), which gives the Board power to impose a fine upon any "person" who fails to report as required. "Person" is not separately defined in either chapter 17 or Title 24, and the generally accepted meaning elsewhere in the code, as discussed in this report, includes individuals, corporations, associations, but not the State or its law enforcement or other agencies. If the duty of mandatory reporting is to reside with all state agencies as well as law enforcement agencies, the definition of "person" under the

statute needs to be broadened to include all mandatory reporters under subsections 1731A(a)(1-6).

5. Require Third Party Presence When Physicians Treat Minors – *Statutory Change Required*

The American Academy of Pediatrics' ("AAP") guidelines explicitly recommend that an adult be present whenever a medical doctor is treating a minor patient. The MPA, however, currently imposes no such requirement on medical licensees. Therefore, the MPA should be amended consistent with the AAP guidelines to require that an adult (parent, guardian, or staff) be present whenever a medical licensee is treating or in the presence of a minor patient.

6. Change the BMP's Complaint Process to Give DPR Investigators Final Determination Whether to Refer a Case for Prosecution – *Statutory Change Required*

When a complaint is filed against a professional licensed under any other chapter of Title 24, a DPR investigator makes the final determination as to whether that complaint should be forwarded to the DOJ (along with the recommendation of a contact person or co-investigator from the appropriate licensing board). In other words, the DPR investigator is vested with the final say of whether complaints are forwarded for potential prosecution. This is not, however, the process followed by the investigators for the Board of Medical Practice. Under the current MPA, the co-investigating physician (and not the DPR investigator) determines whether to close a complaint or send it on for review by the DOJ. The co-investigator physician effectively decides whether to proceed against the physician. This arrangement creates a structural conflict of interest, or at least creates the appearance of one, that could be remedied by amending the MPA so that DPR investigators—and not co-investigating physicians—are vested with the

discretion to forward a complaint to the DOJ for potential prosecution at the close of a DPR investigation.

7. Require the BMP and the DPR to Report Complaints Alleging Criminal Conduct to Law Enforcement – *Statutory Change Required*

Although section 1731A of the MPA currently mandates reporting of unprofessional conduct to the BMP, there is no reciprocal onus on the BMP to report potentially criminal conduct of licensees to law enforcement agencies. To provide the greatest protection to the public, changes should be made to Chapter 87 of Title 29 and the MPA indicating that the DPR and the BMP, upon receiving a complaint involving potential criminal conduct must immediately report the complaint to police and the DOJ. To effectuate the proper investigation and prosecution of any criminal conduct without interference, the statutory change should make clear that the DPR and BMP may institute no civil investigation until they are notified in writing by police or the DOJ that the criminal investigation is closed—either due to criminal prosecution, plea, or the decision that prosecution is not possible—and they may now proceed with an administrative investigation. Further, DPR and BMP investigators should be included as mandatory reporters of any complaints involving minors pursuant to section 903.

8. Amend the MPA to Clarify that an Attorney General Subpoena Supersedes the Peer Review Privilege – *Statutory Change Required*

As part of this investigation, the DOJ issued an Attorney General's ("AG's") subpoena to the MSD demanding, in part, production of "[a]ny and all copies of any minutes of any meetings of the Society, including but not limited to the minutes of the Physician's Health Committee, dated November 10, 2004, and including any committee or subcommittee, concerning the fitness of Dr. Earl B. Bradley to practice medicine, including any discussion about whether to file reports regarding Dr. Bradley to the Board of Medical Practice or any other entity." In response,

the MSD moved to quash the AG's subpoena, arguing that minutes of PHC meetings, during which PHC members discussed allegations of misconduct against Dr. Earl Bradley, are privileged from disclosure to the DOJ under the "peer review privilege." 24 *Del. C.* § 1768(b).

On April 7, 2005, Beebe Hospital was served with an Attorney General's subpoena seeking any records relating to discipline or complaints against Dr. Bradley. While initially claiming no such records existed, Beebe later claimed that to the extent they existed, they would not be disclosed pursuant to the "peer review privilege."

Section 1768(b) of the MPA instructs that "the records and proceedings of committees and organizations described in subsection (a) of this section are confidential . . . [u]nless otherwise provided by this chapter." 29 *Del. C.* § 2504(4), however, provides that "[t]he [DDOJ] and the Attorney General shall have the following powers, duties and authority . . . *[t]o investigate matters involving the public peace, safety and justice and to subpoena witnesses and evidence in connection therewith* . . . ." "The statutory power exercised by the Attorney General pursuant to 29 *Del. C.* § 2504(4) constitutes a broad grant of authority to [him] to discharge the responsibilities of [his] office, including the investigation of possible violations of State law."[48] In order to facilitate the DOJ's ability to investigate matters involving the public peace, safety and justice, sections 1768(b) of the MPA must be amended to expressly state that the peer review privilege is not a basis to resist a subpoena issued by the Attorney General.

9. Modify the Board of Medical Practice's Disciplinary Standards and Reference Sexual Misconduct as a Basis for Discipline under the MPA– *Statutory Changes Required*

Unlike the statutory scheme in many states, Delaware's Medical Practice Act requires proof of misconduct, incompetence or *gross negligence* in the practice of medicine in order to

[48] *In re Frank Acierno*, No. 280, 1990, 1990 WL 168272, at *1 (Del. 1990).

discipline a medical licensee. Although this standard of proof goes more to medical practice errors than misconduct, the MPA should be amended to change the standard for discipline from gross negligence to simple negligence because the gross negligence standard (1) prevents the Board from imposing discipline in a large number of cases where it is warranted and (2) contributes to some degree to the Board's egregiously low disciplinary statistics vis-à-vis other states.[49]

Further, the list of offenses for which discipline may be imposed pursuant to 24 *Del. C.* § 1731(b) should be amended to specifically reference sexual misconduct as a basis for discipline. Finally, the MPA should be amended to include statutory language that would mandate revocation for felony sexual offenses.

10. Add Licensee Duty to Report Violations to the Enumerated List of Items Defined as "Unprofessional Conduct" – *Statutory Change Required*

Under the current MPA, a medical licensee's violation of the section 1731A duty to report is not included in the section 1731(b) enumerated grounds for which the Board may discipline a licensee. Indeed, the MPA as currently drafted only permits the BMP to levy a fine (between $250 and $5000) against a medical licensee that has run afoul of section 1731A. Medical licensee duty to report violations should be added as a ground for disciplinary action under section 1731(b) so that the BMP is empowered to impose on medical licensees who commit section 1731A violations the entire range of discipline with which the Board is statutorily vested (*i.e.*, revocation, suspension, probation, *et*.).

[49] *See, e.g.*, Public Citizen Reports on State Medical Board's Disciplinary Actions, *available at* http://www.citizen.org/Page.aspx?pid=1248 (last accessed May 10, 2010).

11. Mandate the Board Investigate Verbal Complaints of Unprofessional Conduct – *Statutory Change Required*

The MPA currently mandates that the Board of Medical Practice investigate all reports of unprofessional conduct by a licensee regulated by the Board so long as two conditions are met: (1) the complainant identifies him or herself; and (2) the complainant provides the complaint to the Board *in writing*. 24 *Del. C*. § 1733(b); ("The Executive Director shall investigate in accord with the procedures set forth in § 1732 of this title each complaint which appears to be valid and well-founded."); *id*. § 1733(c) ("A complaint against a person to whom a certificate to practice medicine has been issued must be in writing, and signed by the complaining party."). The MPA further permits—but does not require—the Executive Director to investigate unwritten complaints. *Id*. § 1733(c) ("The Executive Director may also investigate an unwritten complaint at the Executive Director's own discretion, provided the complaining party is identified."). In light of the facts that were revealed by this investigation, the decision whether to investigate unwritten reports should not be left to the discretion of the Executive Director; rather, sections 1733(b) & (c) of the MPA should be amended to require the Executive Director to investigate all well-founded reports whether they were submitted in writing or otherwise.

12. Permit the Board to Accept and Investigate Anonymous Complaints – *Statutory Change Required*

As explained above, the MPA currently permits the Board to accept and investigate complaints only if the complainant identifies him or herself to the Board. 24 *Del. C*. § 1733(c) enables the BMP Executive Director to withhold the name of the complaining party but still requires the complainants to identify themselves on the written complaint. Further, 29 *Del. C.* § 8735(h)(1) requires that any complaint against a licensee be made in writing. A legislative change to Titles 24 and 29 should be enacted that would permit the DPR and BMP to accept and

investigate anonymous complaints in addition to those in which the complainant identifies him or herself to DPR.

13. Incorporate Broader Mandatory Self-Reporting Provisions into the MPA – *Statutory Change Required*

Under the current MPA, DPR and the BMP are often unaware of pending and closed disciplinary complaints in other states concerning applicants, and currently licensed or certified practitioners. The MPA should be amended to require applicants for licensure and current licensees to disclose any pending or closed complaints against them by any other licensing jurisdiction, hospital, employer, *etc*. This proposed amendment should include language that vests the Board with the authority to demand all applicants and current medical licensees disclose the circumstances surrounding the extra-jurisdictional pending or closed complaint as well as language that makes clear that any such complaint is a basis for the Board to hold a hearing to deny, suspend, or revoke licensure or take any other appropriate disciplinary action against a current medical licensee.

14. Provide Complainants Pre-Complaint Access to an Investigator – *Statutory Change Required*

DPR recently implemented a process that allows complainants to speak directly to a DPR investigator in regard to their complaints. Prior to implementation of this process, DPR simply routed individuals to the Division's website to file a complaint. The MPA and 29 *Del. C.* § 8735 should be amended to require the Division to memorialize DPR's new procedure of permitting potential complainants access to a DPR investigator to discuss issues or concerns regarding their reports or complaints.

15. Mandate DPR Use of National Licensing Databank Proactive Reporting Service – *Statutory Change Required*

DPR recently subscribed to the National Practitioner Databank Proactive Reporting Service. This subscription entitles the Division to receive proactive notification of all disciplinary actions taken against medical licensees in other states. The MPA should be amended to require DPR to subscribe to NPD's proactive disciplinary notification service going forward so that upon receipt of such disciplinary notifications concerning BMP-licensed or certified practitioners, the appropriate disciplinary action may be taken by the BMP pursuant to 24 *Del. C.* § 1731(b)(19), which currently permits the BMP to discipline any licensee when s/he has been subjected to "other disciplinary action taken by the regulatory authority in another state or territory."

16. Streamline the BMP's Emergency Suspension Process – *Statutory Change Required*

Recent BMP medical license suspensions demonstrate significant problems with the current emergency suspension process. Although the current MPA allows the Board to convene on 24 hours notice to consider an emergency suspension, no emergency suspension hearing may proceed under the MPA unless a quorum of the Board (9 members) is present for the hearing. 24 *Del. C.* § 1738(a). Moreover, even if a quorum of the Board is present for the hearing, the Board still may not issue an emergency suspension of a medical license unless seven (7) Board members vote affirmatively to so proceed. *Id.* Experience demonstrates that the primary difficulty presented by this process is the gathering of a quorum of the Board in the first instance on such short notice. Accordingly, the emergency suspension process must be streamlined by amending the MPA to enable the Board President and either the Secretary of State or the DPR

Director to sign off on the licensee suspension on the pleadings accompanied with amending language that provides the right to a speedy post-deprivation hearing to medical licensees.

Under section 1738(a) of the current MPA, "[a]n order of temporary suspension pending a hearing may remain in effect for no longer than 60 days from the date of the issuance of the order unless the temporarily suspended person requests a continuance of the hearing date. If the person requests a continuance, the order of temporary suspension remains in effect until the hearing panel convenes and a decision is rendered." In other words, where the BMP has suspended temporarily a medical licensee's license to practice, the BMP is mandated to reinstate that license to practice medicine after 60 days unless the licensee respondent requests a continuance. The practical result of this requirement is that, with regard to physicians with temporarily suspended licensees, DPR investigators must complete their investigation of those physicians and the DOJ must be prepared to prosecute those physicians before the Board in less than 60 days or that respondent is entitled to automatic reinstatement of his or her license. Needless to say, a thorough investigation and professional prosecution often require more than 60 days to complete. As such, the MPA must be amended to permit the Board to extend the 60-day suspension, upon motion of the DOJ prior to expiration of the 60-day temporary suspension period, where such an extension is in the public interest.

17. Mandate Hospitals Report All Actions Restricting Medical Licensees' Privileges to the Board of Medical Practice – *Statutory Change Required*

Under the current MPA, a hospital has a duty to report any limitations of privileges against a medical licensee. 24 *Del. C*. § 1731A(b). The federal Health Resources and Services Administration regulations promulgated pursuant to section 1921 of the *Social Security Act*, on the other hand, only require hospitals to report "[p]rofessional review actions that adversely

affect a practitioner's clinical privileges *for a period of more than 30 days*" (emphasis added). 45 C.F.R. § 60.11(a). A review of the section 1731A reporting statistics over the 2000-10 time period suggests that hospitals use the section 1921 "more than 30 days" provision as a threshold triggering their section 1731A duty to report "actions that affect a practitioner's clinical privilege" despite the fact that there is no "exceeds 30 days" provision in the MPA. As a result, the MPA should be amended to require hospitals to report any discipline or conditions imposed on medical licensees to the BMP no matter the length or severity of the discipline or conditions and notwithstanding any other reporting criteria.

18. Strengthen Penalties for Failure to Comply with the Duty to Report – *Statutory Change Required*

Under the current MPA, the penalty range for a violation of the section 1731A duty to report is a fine not less than $250 and not greater than $5000 per violation. 24 *Del. C*. § 1731A(i). It is obvious that Delaware's failure to report penalty range is disproportionately low. Therefore, the MPA should be amended to permit the Board to issue fines as discipline—where appropriate—for any failure of a medical licensee to report unprofessional conduct.

19. Require Criminal Background Checks for Medical Licensees at License Renewal – *Statutory Change Required*

Under the current MPA, the registration of a certificate to practice medicine must be renewed by all licensee/registrants biennially. 24 *Del. C*. § 1723(a). The Board of Medical Practice, however, does not conduct criminal background checks on medical licensees upon their application for certificate renewal. *Id*. § 1723(c). Instead, the BMP's renewal process relies entirely on physician self-disclosure. *Id*. Therefore, the MPA must be amended to either (1) permit the Division to conduct post-renewal audits that include criminal background checks; or

(2) permit the Division to automatically receive criminal history updates on medical licensees from the State Bureau of Investigation ("SBI").

20. Recommend All Mandatory Reporting Agencies Implement Agency-Wide Reporting Policies and Procedures – *No Statutory Change Required*

This report demonstrates that none of the mandatory reporting agencies had developed or implemented section 1731A or section 903 reporting policies and procedures or included the reporting requirements of those sections in their policies and procedures manual. As such, it is recommended that each mandatory reporting agency create agency-wide mandatory reporting policies and procedures as soon as practicable. The DOJ's recently-implemented reporting policy can be found at Exhibit 19 in the index to this report and could be a useful starting point for mandatory reporting agencies.

21. Broaden the Class of Mandatory Reporters in 16 *Del. C.* § 903 to Include Entities in Addition to Individuals– *Statutory Change Required*

Currently, the child abuse reporting requirements are limited to professionals and other persons. As discussed, the definition of "person" does not include all types of entities, *i.e.*, law enforcement agencies. This report demonstrates that a broader range of entities must be responsible for mandatory reporting under 16 *Del. C.* § 903 in addition to individuals to increase the likelihood that reports of child abuse are made to the appropriate authorities.

22. Grant DPR Access to Police Reports via 11 *Del. C.* § 8513A – *No Statutory Change Required*

Currently, any prosecution before the BMP arising out of an incident that is also the subject of a criminal investigation is severely hindered by the law enforcement investigative privilege. For example, DPR investigators are not able to access police reports from any law enforcement agency regarding any on-going police investigation until such time as the

investigation, and subsequent criminal prosecution—if any—is concluded. Currently, a mechanism exists under 11 *Del. C*. § 8513A which would enable the DPR to apply for access to the Criminal Justice Information System ("CJIS"). Access to CJIS would allow DPR to obtain criminal history information, once such access is approved by the DELJIS Board. Allowing DPR access to CJIS information would greatly improve the flow of information gleaned from any criminal investigation needed for the subsequent administrative prosecution before the BMP. Public safety would be protected, and the criminal investigation not compromised if the DPR investigation does not begin until written notification of the closed criminal investigation is received, as recommended above. In any case closed by law enforcement that is subsequently referred to DPR for administrative investigation, DPR may request police reports from CJIS to further any administrative prosecution of a doctor for unprofessional conduct in a more expedited manner. Further, if the MPA is amended to allow for the continuation of emergency suspensions while the criminal investigation is pending—eliminating the current statutory requirement that a full evidentiary hearing proceed within 60 days of the initial emergency suspension—public safety will be ensured during this time and the BMP will not be forced to go forward with an evidentiary hearing where the majority of the relevant evidence is shrouded from presentation under the cloak of criminal investigative privilege.

23. Establish a Procedure for the Transfer of Medical Records of Revoked Licensees – *Statutory Change Required*

Currently, section 1760 of the MPA establishes clear procedures for licensees who voluntarily close their medical practice. These procedures ensure that current and past patients receive adequate notice of the pending closing and an opportunity to retrieve their medical records. In this way, patient care is not compromised by a decision of a licensee to retire from

practice. No such protocols exist to protect patients whose treating doctor is forced to close his/her practice involuntarily. The purpose of this recommendation is to impose an orderly process to assist patients of doctors who are either arrested or suspended from practice in obtaining medical records for the continuation of ongoing medical treatment or emergency health care. Statutory changes are needed to the MPA including the creation of procedures addressing the appointment of receivers, records custodians, and emergency notification of past and current patients.

24. Improve Transparency of the Board of Medical Practice's Disciplinary Hearings – *Statutory Change Required*

The MPA, as currently enacted, permits medical licensees to have their BMP disciplinary panel hearings conducted in executive session, *i.e.*, confidentially. *See* 24 *Del. C*. § 1734. The BMP is the only regulatory licensing board in all of Title 24 that is permitted to conduct disciplinary hearings confidentiality and out of the public's purview. Such anomalous statutory procedures are viewed as "protect the doctor" provisions and are unwarranted. Accordingly, amendments are needed to the MPA to mandate that the BMP conduct its disciplinary panel hearings publicly rather than in executive session, consistent with the statutory mandate and practice of all other Title 24 regulatory licensing boards and the *Administrative Procedures Act*, 29 *Del. C.* ch. 101.

25. Increase Community Outreach to Improve the Public's Understanding of How to File a Complaint against a Medical Licensee – *No Statutory Change Required*

This recommendation is premised on the conclusion reached in this report that many individuals do not understand how to properly file complaints against medical licensees with the Board of Medical Practice or Division of Professional Regulation. The Delaware DOJ should

post a link on its main webpage and consumer protection webpage that takes constituents to the DPR website to assist them with filing complaints against any license holder and explain the section 1731A reporting process prominently on the public DOJ website. Further, the DOJ should consider creating informational pamphlets that detail the sections 1731A and 903 reporting processes and distribute those pamphlets at public events such as the annual State Fair.

26. Implement Training and Policies at the Agency/Entity Level to Ensure Mandatory Reporters Understand and Comply with their Duty to Report – *No Statutory Change Required*

This compliance review makes clear that mandatory reporters are under-educated regarding their affirmative reporting requirements of sections 1731A and 903. To remedy this deficiency, both the DOJ and the DPR should provide compulsory routine training seminars to mandatory reporters at least annually to ensure that those entities and individuals understand their sections 1731A and 903 reporting requirements.

27. Retain DPR Investigators with Specialized Medical Training – *No Statutory Change Required*

Currently, the DPR investigators receive training and investigators for the Board of Medical Practice are certified as medical investigators before they begin investigating complaints arising out of the *Medical Practice Act*. Evaluation and investigation of complaints concerning medical licensees often require the DPR investigators to make judgments concerning medical practice standards. Lack of access to greater medical expertise not only limits the capability of the DPR to thoroughly investigate complaints; it also makes it more difficult for the State to prosecute medical licensees for MPA violations before the BMP in an administrative hearing. Our recommendation is that investigators assigned to the BMP receive additional, enhanced training to better equip them to properly investigate complaints of unprofessional conduct.

Better-trained DPR investigators will be able to investigate claims of unprofessional conduct from a greater knowledge-based, objective perspective.

V. CONCLUSION

Delaware law governing the affirmative obligations to report unprofessional conduct of physicians under section 1731A of the *Medical Practice Act* and suspected child abuse and neglect under section 903 of the *Child Abuse Prevention Act* mirror the best national standards. This report teaches that many highly qualified professionals in the medical and law enforcement communities nonetheless had difficulty following these reporting obligations in the instant case. The health care institutions and law enforcement agencies reviewed did not have adequate procedures in place to facilitate effective reporting of unprofessional conduct by doctors. Lack of knowledge concerning mandatory reporting requirements under sections 1731A and 903 appears widespread.

Moreover, lack of reporting under those sections evidenced by the various statistics provided in this report indicates there are significant statutory problems that need to be remedied despite the fact that Delaware law follows the model national standards. Particularly, the current mandatory reporting requirements place a heavy burden on medical and law enforcement professionals to make subjective determinations about unprofessional conduct by a doctor often with limited information and often under critical, expedited conditions.

The purpose of this review is to illustrate the myriad problems in the current reporting systems and to implement changes to the current system to protect Delaware citizens, especially those who cannot speak for themselves. Enhanced training to increase awareness of and compliance with the mandatory reporting requirements is crucial to insuring patient safety.

In the coming days and weeks, we fully anticipate that other recommendations will be made to improve the mandatory reporting process. We pledge to work cooperatively with all interested parties and the public to make the necessary changes in the law to enhance the

effectiveness of the mandatory reporting requirements and process, address unprofessional conduct in the practice of medicine swiftly and effectively and, in so doing, prevent the most vulnerable among us—our children—from harm at the hands of trusted and state-licensed professionals.